STATE OF NEW HAMPSHIRE

INSURANCE DEPARTMENT

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Concord, New Hampshire

RE: **PUBLIC HEARING CONCERNING PREMIUM RATES IN THE HEALTH INSURANCE MARKET (RSA 420-G:14-a, V) Second Annual Hearing**

PRESIDING: Commissioner Roger A. Sevigny
(New Hampshire Insurance Department)

APPEARANCES:

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Tyler J. Brannen, Health Policy Analyst
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Court Reporter: Steven E. Patnaude, LCR No. 52

I N D E X

P R O C E E D I N G

CMSR. SEVIGNY: Good morning, everyone. I don't know if it's on. Somebody said it was on.

(Referring to the microphone.)

CMSR. SEVIGNY: Now it's on. Thank you. My name is Roger Sevigny. I'm the Commissioner of Insurance for the State of New Hampshire. I want to welcome you all to this public hearing concerning premium rates in the health insurance market in New Hampshire. It's the second annual public hearing that we have on this issue.

I'm going to start by introducing the Insurance Department participants this morning. Tyler Brannen, who is our Health Policy Analyst; David Sky, who is our Life, Accident, and Health Actuary; Jen Patterson, who is our Life, Accident and Health Legal Counsel; and Michael Wilkey, who is our Life, Accident and Health Director.

Joining us this morning are the consultants on the issue of rates in the health insurance market. Jen Smagula, from Gorman Actuarial; Bela Gorman from Gorman Actuarial; and Don Gorman from Gorman Actuarial.

MS. O'LAUGHLIN: I'd correct that.

CMSR. SEVIGNY: Pardon me?
MS. O'LAUGHLIN: Oh. We have to correct that.
CMSR. SEVIGNY: You have to correct that. Okay.
MS. O'LAUGHLIN: Yes. Don Gorman --
CMSR. SEVIGNY: Sorry, there's a correction.
MS. O'LAUGHLIN: Yes.
CMSR. SEVIGNY: Oh. Jon Camire for Donald Gorman. Thank you for the correction to the record.
MS. O'LAUGHLIN: You're welcome.
CMSR. SEVIGNY: Thank you. Thanks, Deb. The health carrier participants this morning are going to be Anthem Health Plans of New Hampshire, Harvard Pilgrim Health Care, MVP Health Insurance Company of New Hampshire, and Cigna HealthCare of New Hampshire. And, as far as provider representatives, we have, from Dartmouth Hitchcock Medical Center, Dr. John Buttery.
MR. BRANNEN: We also have the New Hampshire Health Plan joining us.
CMSR. SEVIGNY: And, New Hampshire Health Plan is going to be joining us this morning as

well.

New Hampshire 2010 law Chapter 240, 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 are folks from Gorman Actuarial. And, this morning we're going to begin with testimony from New Hampshire's major health carriers, followed by Dartmouth Hitchcock and New Hampshire voices.

There is a sign-up sheet. And, if you'd like to present testimony or make comments or ask questions, I'd appreciate your signing up on the sheet. And, Deb has already provided me with that. But, if there are any additional, I'll invite you to come up and you can sign in to the sheet -- you can sign the sheet as well.

With that, we're going to start with the testimony. And, I'm going to invite in the order that I

just mentioned, the first participants in testimony this morning, starting with Anthem Health Plans of New Hampshire.

MR. BRANNEN: And, for the folks that are listening remotely on the phone system, please just put your phone on mute so that we don't hear any noise from your end. Thanks.

MS. GUERTIN: Good morning. My name is Lisa Guertin. And, I am the president of Anthem Blue Cross and Blue Shield in New Hampshire. Thank you very much for the opportunity to share information with you today.

The Department posed six specific questions for this year, which I will answer directly. But, before I do, we thought it might be helpful to provide some high level information, as we did last year, as context for the specific answers that will follow.

And, I'll start with something very basic, that I recognize most of you know, and that is that insurance premium is comprised of expense associated with health care services received by our members, or claim costs, and expense associated with the health insurer's administrative services and margin. So, that includes costs associated with care management, processing claims,

enrollment, customer service, building and maintaining a network, as well as taxes and assessments, or administrative costs.

During the period of analysis for this hearing, which was 2010 into 2011, for Small Group we filed rates intended to support 81.5 percent of premium going toward claims; 3.9 percent as margin, which as you'll see is important, because rates are set using a forecast of expected claims for more than 12 months into the future, which can and does vary. So, this margin is used on claim expense when claims come in higher than forecast, and is retained as profit if they don't. In our filing, we assumed 9.8 percent would go toward administrative costs; and 4.8 percent would be a pass-through of known assessments and taxes, including federal tax.

You may recall from our testimony last year that, in both 2009 and 2010, claims took more than anticipated in our filing. In contrast, in 2011, claims took slightly less than we assumed they would. So, that gets us to our first question from the Department, which is "What did we assume about unit cost, utilization and mix in our 2011 premium development?" And, overall, our filing for 2011 assumed that all elements of our premium

development would perform close to their long term average increases.

So, specifically, for utilization, which is the amount of care people are receiving, and mix, which is the assortment of simple and complex services that they get, we assumed when we filed that increases would be right at their long term averages.

For unit cost, which is the amount we pay a hospital or doctor for a particular service, we expected that the price inflation for each outpatient and professional service would be slightly more than the historical average. We also assumed we would see a higher Rx prescription trend in 2011 than in 2010.

So, Question 2 asks us "What actually happened?" And, as reported in the Segal Health Plan Cost Trend Survey, across the industry as a whole, actual trend rates for 2010 were the lowest recorded in more than ten years, and there was a significant spread between actual and projected trends. That industry phenomenon affected us, too. And, unlike in 2009 and 2010, claims took less than expected when we filed our rates. So, I'll break that down just a little bit for you.

For institutional services, that's hospitals and other facility-based services, utilization

and mix were right on our premium development expectations. Our unit cost for institutional services was more favorable, i.e., came in lower, than expectations.

For outpatient and professional services, unit cost and utilization were both favorable to expectations. And, Rx trend was slightly higher than we assumed it would be when we made our filing.

We believe that lower utilization occurred for a variety of reasons, some of which I'll address when I talk about our innovation in products and services. But, beyond those things, macro factors, such as the weak economy, and, here in New Hampshire, even the extreme weather in January and February of 2011 served to dampen utilization. And, while this does help to moderate the premium cost increases our customers see year over year, there's certainly some concern about whether people are foregoing necessary services that could increase the frequency of more complex medical care down the road.

By category, the services with decreases in utilization year over year included outpatient lab, ER services, radiology, and preventive services, just to highlight a few. In contrast, some categories had increases in utilization, including, for us, inpatient

medical, maternity, and medical services in physician's offices, like chemotherapy, dialysis, and dermatology.

Question 3 asked about "changes or innovations that have been implemented since 2010." So, what are we doing to try to control the rise in health care costs? I'll start with product and benefit.

And, strategically, our product and benefit focus since 2010 has been on three major things: Bringing affordable options to the market place; engaging members as active consumers of care and as stewards of their own health and wellness; and standardizing and simplifying our offerings to help with administrative costs and ease of doing business.

As many of you probably know, the Northeast has among the highest rates of benefit buy-down in the country, averaging around 10 percent. So, that means, when a customer sees their premium increase, they are choosing to reduce the level of benefit richness in order to offset or mitigate some of that increase. So, it's been essential for us to offer creative buy-down options, using designs other than just continuing to increase the size of that front end deductible, which can, in fact, turn into a barrier to receiving care. Our site of service benefit options, for instance, leverage the

concept of consumerism and allow our members to achieve savings on their out-of-pocket expense, if they're price-sensitive consumers of certain services, like lab and ambulatory surgery. Based on the success of this product, since 2010 we've made it our standard benefit design for our Small Group plans.

Other benefit changes tied to affordability include annual benefit changes that help keep our products in step with changes in medicine. So, two examples would be introducing differentiated cost sharing for high-cost specialty drugs and for high tech imaging services.

Member engagement is our second important theme, and our goal is to engage members in two ways: As consumers of care and as active participants in maintaining or improving their own health and wellness. Our approach provides tools and information so people can understand their options; and incentives to use those tools and get engaged.

Because Question 4 asks us specifically about transparency, I won't describe those now. But, since 2010, we also brought to market an innovative incentive approach called "Anthem Health Rewards", which allows an employer to create customized incentive rewards

for various health-related activities, with online point and reward tracking. And, incentive options can include things like account deposits, gift cards, and premium contributions.

Simplification, which is our third theme, was especially important in our Individual plan portfolio, which got a complete refresh during 2010. We increased efficiency by decreasing variation within the portfolio, and also simplified the purchasing process for consumers by creating three distinct grouping of products, that range from least rich, Lumenos Plus HSAs, to the most comprehensive Premier plans, with SmartSense plans falling in between.

Question 3 also asked about our innovations in medical management and provider reimbursement. In the interest of time, I'll highlight just a few programs in these areas. In medical management, our focus has been on delivering high value programs that help ensure medically necessary care is delivered in the right setting, without adding unnecessary administrative burden or expense. So, this includes things like introducing OrthoNet review of physical and occupational therapy; AIM review of high end radiology; developing the availability of Home Infusion for members

on certain drugs; and our Emergency Room Utilization Management Initiative, which educated about appropriate use of urgent care centers instead of the emergency room.

Since 2010, we're very proud of the fact that we've made extensive progress in our payment innovation as well. We now have our Quality Hospital Incentive Program in place with 14 hospital systems, and our Anthem Quality Insights Program in place with over two-thirds of contracted primary care physicians. In October of 2010, Anthem entered into a risk-sharing arrangement with approximately 25 percent of the providers in New Hampshire through its Accountable Care Organization, or ACO, payment model with Dartmouth Hitchcock. This is a true risk-sharing arrangement with both up- and downside risk, and we recently extended it through June 2014. In addition, we're in discussion with several large health systems in the state regarding development of similar ACO models, which we'll begin in 2013.

We also anticipate we will have more than 200 practices participating in our brand new Patient Centered Primary Care Program. This program builds and expands upon our patient centered medical home successes in New Hampshire and in other Anthem states by offering

physicians access to meaningful and actionable patient information, as well as complex care management resources for their office. Primary care physicians who participate and achieve cost savings while maintaining or improving quality will have the opportunity to earn additional revenue through a shared-savings model and will also receive a Per Member Per Month payment, with an initial focus on preparing care plans for patients with multiple and complex conditions.

In turn, those physicians will be required to commit to practice transformation, including expanded access for patients; active complex care management and planning; and demonstration of required quality standards.

With these ACO payment models, and broad participation in our Patient Centered Primary Care initiative, we expect that nearly 75 percent of our members will be touched by one of these transformative, innovative provider payment strategies.

Question 4 asked "To what extent are you providing commercial members transparency in terms of cost and quality of services?" Because of our strategic focus on consumerism and member engagement, the answer is "to a great extent." And, I'll highlight four of our most

important transparency initiatives.

The first is Anthem Care Compare, which was initially launched in 2006. This is an innovative online transparency/comparison tool that discloses real price ranges and quality data for 168 common services, including facility, professional and ancillary services. The number of services covered in Anthem Care Compare will expand to over 200 by the end of this year.

We also offer the Blue Precision Physician Recognition Program, which shares information about physicians' quality and cost performance with members so they can have added confidence when choosing a specialist. Blue Precision is available for specialists such as endocrinologists, pulmonary -- pulmonary medicine specialists, rheumatologists, cardiologists and OB/GYNs.

One of the innovations we're most excited about is our exclusive partnership with Compass Healthcare Advisers to develop the SmartShopper Program, which assists members in evaluating costs at facilities for a variety of procedures and health care services, and financially rewards members for choosing more cost-effective locations for the services they receive.

And, finally, we offer the Zagat Health Survey, which enables members to provide feedback on their

experience with physicians, creating a trusted resource for other members to assist in their decision making.

Question 5 asked "What is the premium cost of New Hampshire coverage mandates implemented since 2006? And, has the experienced cost been more or less than originally projected?" Since 2006, the cost of mandates have averaged about two and a half percent of premium. We prospectively price the cost of mandates based on the best available information at the time. Once a mandate is in effect, we no longer monitor it individually because the true cost is reflected in our experience.

On average, we believe our mandate assumptions are reasonably close to the true costs, although the actual experience for any specific mandate can be greater or lesser. And, I'll give you two examples. For the autism mandate, we predicted a cost of just about $2.00 per member per month, which was consistent with industry expectations. Since the mandate went into effect in January of 2011, the experience has not supported that full original estimate. We do expect that the autism mandate may generate future costs as our members become more familiar with the benefit, but until that time the lower costs are factored into our pricing,

because they do show up as part of our experience.

An example of a mandate where our estimated cost has been borne out pretty closely through experience is the hearing aid mandate, where we predicted a cost of 63 cents per member per month, and have seen actual costs track very closely with that.

And, finally, the last question was very straightforward: "Did we pay any premium rebates in New Hampshire in 2012 based on 2011 performance?" And, the answer is "no, we did not." And, while you'll recall that I stated at the beginning of my comments that claim costs came in lower than anticipated in our rate filing, the fact that no rebates were triggered demonstrates that we have continued to do an effective job establishing rates that appropriately reflect the dollars we'll need for claim and administrative expense.

So, in closing, I do hope I fully addressed the questions provided, and contributed to this important dialogue about health care and health care costs within our state. Going forward, our focus at Anthem will continue to be on developing a range of solutions to improve the accessibility and affordability of quality health care for our members, and on doing our part with other stakeholders to help transform the current

fragmented, uncoordinated and costly health care model to a more coordinated, patient-centered and value-based system. Thank you.

CMSR. SEVIGNY: Great. Thank you very much, Lisa. I have got a question for you, and then I'll ask staff and our consultants if they have got any questions for you.

My question goes to our Question Number 5, regarding mandates and the cost of mandates. Mandates are in the news all the time as being the reason that the health care system is out of control. Yet, you've just testified that mandates overall account for about 2.5 percent of premium. That's total premium?

MS. GUERTIN: Right. Now, that would be tied to the mandates since 2006, correct? In our filing, we were asked to isolate those that have passed since 2006.

CMSR. SEVIGNY: Correct.

MS. GUERTIN: So, Commissioner, any that have been in sort of on a long-standing basis wouldn't be included in that number.

CMSR. SEVIGNY: So, from that, can I draw some sort of conclusion that says that, if those mandates were eliminated, consumers overall would see a

2.5 percent reduction in their premium possibly?

MS. GUERTIN: I believe that, as long as we're isolating those mandates --

CMSR. SEVIGNY: Those mandates, yes.

MS. GUERTIN: -- that passed since 2006, and, you know, we can itemized those, that, yes, that would correlate.

CMSR. SEVIGNY: Okay. Thank you.

MR. BRANNEN: A question. You made reference to the buy-down in, I think, in the Northeast versus potentially elsewhere. Could you talk a little bit more about that? I mean, potential reasons or --

(Court reporter interruption.)

MR. BRANNEN: -- potential reasons for the buy-down being greater in the Northeast or --

MS. GUERTIN: Sure.

MR. BRANNEN: And, how much different is it?

MS. GUERTIN: Yes. You know, I think that it's directly tied to the fact that our premiums are higher in the Northeast. We know that, depending on which study you reference, we are certainly in the top five states in terms of health insurance premium cost. And, so, it's really driven by the affordability challenge.

And, looking within Anthem, where we are the major market leader in 14 states, I would say we're about double. If they see something in the neighborhood of five, five or six percent buy-down per year, and we have pretty consistently, for the past few years, seen about a ten percent buy-down here in New Hampshire.

CMSR. SEVIGNY: Other staff, Jennifer or Michael? No. Or our consultants?

MS. SMAGULA: Yes. I've got a question. You mentioned your site of service program. Do you have any estimates on the cost savings resulting from that program that you could share with us?

MS. GUERTIN: Well, we do know that, as a buy-down option, when we introduced it and priced it, it did allow a sizable buy-down alternative for our customers, in the upper single digits, I believe, was sort of the price relativity that we were able to offer. And, it has performed well, which would suggest that that was an accurate reflection of the cost savings that it would drive.

MS. SMAGULA: And, another question. Could you comment on if the federal MLR requirements have had any impact on your pricing in 2001 or going -- 2011 or going forward?

MS. GUERTIN: I'm sorry. Can you -- specifically, do you mean have we have filed different rates because of the MLR?

MS. SMAGULA: Yes. Anticipating the federal MLR requirements, has that had any impact on your pricing going forward?

MS. GUERTIN: No. In the group market, not at all. I mean, we find that we're right in sort of in the zone that we need to be in any way. I know that, on the individual side, there was a -- actually, what is that referred to as? We had years to sort of step down to the MLR?

MS. PATTERSON: Waiver.

MR. WILKEY: A waiver.

MS. PATTERSON: A waiver.

MS. GUERTIN: A waiver. That's the word, "waiver". And, so, in that we've definitely been making sure that we are tracking to bring that MLR down over time on the individual side.

MS. SMAGULA: And, one last question. You mentioned, you were talking about ACO and your risk-sharing program, you currently have about 25 percent of your providers on that type of arrangement, in 2013 you'll have a lot more. Do you have a sense of, on a

percentage basis, how many more will be joining in 2013?

MS. GUERTIN: Yes. Well, it's really a combination. I mean, we will be in the market with two different payment innovation programs as I mentioned. And, one is the full ACO model, like we have with Dartmouth Hitchcock today. And, we do think that several other hospital systems will likely come on board with a similar arrangement. The Patient Center Primary Care, which again is a true, you know, gain-sharing model for primary care practices, really gives us a very broad reach into the market.

So, when those two programs are sort of fully up and running, we think that it will be about 75 percent of the market, and, therefore, of our membership. Now, we won't get all the way to that number in 2013. But, I would think, over the next perhaps two years, we would be at three-quarters of our membership in some sort of payment innovation model.

MS. SMAGULA: Thank you.

MS. GUERTIN: Uh-huh.

MR. WILKEY: Lisa, I have a question please. Could you speak to the impact on the loss ratios and the claims relative to the elimination of pre-existing conditions for children under 19 under ACA?

MS. GUERTIN: Let me think. Say that one more time, Mike.

MR. WILKEY: Can you speak to the elimination of pre-existing conditions being applied to children under age 19 in the individual market as required under the Affordable Care Act?

MS. GUERTIN: In terms of whether we saw an impact on our experience?

MR. WILKEY: Yes.

MS. GUERTIN: You know, I think, when you look at the performance of our individual book, we've priced pretty well. I mean, I think we've had a good, tight correlation between projecting costs and putting the price in the market, and then seeing the product perform. And, I would say, based on the performance of our individual book, I think we've -- it's flowed in fairly seamlessly.

MR. WILKEY: Thank you.

CMSR. SEVIGNY: Other staff or Department representatives?

(No verbal response)

CMSR. SEVIGNY: Good. Thank you very much, Lisa.

MS. GUERTIN: Okay. Thank you.

CMSR. SEVIGNY: Next, I'd like to ask the representative from Harvard Pilgrim Health Care to please come up.

MR. GRAHAM: Good morning. My name is Bill Graham. I'm the Vice President of Policy and Government Affairs at Harvard Pilgrim Health Care. Joining me here this morning, I have Peter Horman, who's our Director of Actuarial Trend Analysis, and Theresa Galinaro, who is our legislative consultant.

Harvard Pilgrim is a not-for-profit organization providing health benefits to about 1.1 million individuals throughout New England, including about 130,000 individuals who obtain coverage through New Hampshire-based employers. Our parent company has just once again been rated as the top rated health plan in the nation for the ninth consecutive year. And, our New Hampshire affiliate is the top rated health plan here in New Hampshire.

The topic of this morning's hearing about health care costs, as we all know, the rate in health care costs remains a major concern. As I will discuss later in my testimony, Harvard Pilgrim continues to do its part to control the rate in growth in health care costs. That said, there are many environmental

factors leading to cost growth that are beyond any one insurer's control. In September of last year, the New Hampshire Center for Public Policy Studies noted that health care spending in New Hampshire has been increasing more rapidly than the nation as a whole -- than economic growth. The report ascribed the growth not only to more people seeking care and the price of this care, but also to New Hampshire's population. By 2030, nearly a third of New Hampshire residents will be over the age of 65. This has tremendous implications for the health care system since older individuals need and use health care services to a much greater degree than younger individuals.

In a report issued by the Center in March of this year, the Center looked at the relationship between provider competition, payer mix and prices paid to hospitals. The report noted, while increasing hospital competition is associated with lower prices, the larger predictor of prices is the aging of the population, the share of a hospital's revenue that comes from Medicare, and the resulting cost-shift onto private payers. Since Medicare pays for acute services for persons over 65 at a lower rate than private insurance does, and because of federal budget constraints, this payment gap will only grow over time. As a result, providers attempt to recover

their costs by asking for higher payments from private insurers, which leads to higher premium costs. It's a vicious cycle that will only worsen unless fundamental changes are made to how we pay for and deliver care.

We know that this particularly impacts small businesses, and their premium rate increases have been a particular issue. On average, small businesses tend to have older employees and their use of health care services is higher. Even though medical cost trends have moderated in the latter part of the last decade, those costs continue to rise, and the aging of the population adds about another 2 percent to medical cost trend. It is understandable why small businesses remain concerned about the premiums that they pay. We are particularly concerned that things are going to be exacerbated in the next few years as we implement major provisions of the Affordable Care Act, most notably the premium tax that will apply to fully insured businesses starting in 2014, and the essential health benefit requirements that, among other things, will limit deductibles in the small group market to $2,000 for an individual. We see many, many businesses in New Hampshire, who are currently buying higher deductible products and are concerned about the buy-up that is going to occur in 2014 as a result of this and the

impact that will have on their premiums.

The remainder of my testimony will focus on the specific questions the Department asked carriers to address in their testimony. The first question was about the "primary drivers of unit cost, utilization, and mix assumptions used in 2011 premium rate development".

In developing premiums for 2011, we continue to assume that the largest driver of the trend increases will be provided in unit cost increases. In particular, increases in specialist visits, outpatient surgeries, and high-cost injectable drugs and prescription drugs were the most material factors that we expected to drive the trend upwards.

Buttressing this assumption was an increase in the large inpatient claims that we saw in 2010 that lead us to believe that they would continue into 2011. In addition, in 2010, we saw additional claims associated with genetic testing. Folks may recall, this is something we'll talk about later, but the Department actually took action on to counteract the trends that we were seeing. These were the testing that UMass Medical Center was doing to test folks that was going on in the malls and the like, and we saw that in our claims in 2010, and assumed that would continue into 2011.

On the flip-side, there was a development in 2010 that led us to reduce trends into 2011, and that was generic Lipitor becoming available in the marketplace. It's a very high-use drug. And, the fact that a generic version became available allowed us to include assumptions to reduce our trends as a result of that.

The second question is "what were the primary drivers of -- that we actually experienced, our trend experience from '10 to '11?" When we reviewed the actual experience, compared to what we had expected, we found the actual trend was lower in 2011 than what we had predicted going into the year. Some of the drivers of this were more favorable provider negotiations that allowed us to make adjustments to the provider unit cost trend. In addition, there were certain claims categories where we experienced a more favorable experience than we had initially anticipated. The first was what we talked about earlier with the genetic testing. There was action taken by the State of New Hampshire to reduce the use of those services, and the rate of payment that we paid for that, there was a law passed that capped what we could pay for those testing to $150, and that positively impacted the trend.

We also experienced a relatively large drop in high claims volume compared to what we had anticipated to see. Some of this, and I think Ms. Guertin noted this in her testimony, we're still not sure how much of this is reduced demand for services caused by the economy and people putting off elective surgeries, versus an actual reduction in demand. And, that remains something that we continue to watch very closely.

There was an unexpected drop in volume of high-cost injectables from 2010 to 2011. And, then, also positively affecting our actual trends in 2011, compared to what we had predicted, were some new utilization management programs that Harvard Pilgrim put into place in 2011. Most notably, we put in a new medical management program related to sleep studies that helped bring down cost trends.

Certain factors also, however, are driving trends up, compared to what we had originally anticipated for 2011. Outpatient surgery utilization continues to increase. In April of 2011, a new Hepatitis C prescription drug entered into the market. There is no generic of this drug available, and that has increased trends. There were additional mandates, as we've talked about earlier in this hearing, that came into effect as

well that have impacted trend.

The third question the Department posed were "what about changes or innovations that the plan has implemented since 2010?" I'm going to talk about three areas: Product offerings, medical management programs, and provider payment models.

In the product offering area, Harvard Pilgrim has introduced two tiered -- new tiered network products to the market since 2010. These are our ChoiceNet products and our Hospital Prefer products. We also have launched a new service for our customers called "SaveOn" that I will discuss.

ChoiceNet is a tiered network plan. It divides our network of physicians and hospitals into three tiers, based on cost and quality data. The cost share that the member pays varies based on the tier the provider is placed in. So, low cost/high quality providers, there's a lower co-payment than if a member seeks to receive care from a higher cost provider.

We really have two goals with this product. The first goal is to increase member awareness of the actual cost of services and to encourage members to seek care from more cost-efficient providers when they were available to them. The second goal of the product is

really to change the conversation that we have with the provider community. When we go out and talk to providers about the fact that you are in the top tier because you are more expensive, some of the providers want to know, what can they do to move down into a tier where the member is going to pay a lower cost payment -- lower cost share. And, in some instances, we've actually had some concessions at the negotiating table that providers have made in order to affect their tier placement.

We've launched a second product called "Hospital Prefer". That product is similar to ChoiceNet, in that the network is divided into three tiers. However, in that product, only hospital services are subject to tiering; physician services are not.

In addition to these new products, we also launched a new service referred to as "SaveOn" for our customers. This is being provided to all of our small group customers here in New Hampshire. It's also available as an add-on for large group and self-funded customers who choose to purchase it. And, again, here the goal is to redirect members to more cost-effective settings to receive care. There are particular services, such is MRIs, where, if the member needs the service, they call in, and they speak with a nurse, they talk about what

has been prescribed and where they had been referred to go. If there's a more cost-effective facility in the area that's available to them, the nurse will set up a new appointment at the new facility for them. And, if the member receives services at that facility, they actually receive a cash incentive for having moved to the lower cost facility. So, everyone wins. The member gets a cash incentive, and we see lower costs that are passed through to the employer groups, hopefully, as we go forward, in the form of lower premium trends going forward.

In the medical management program space, this is an area I think where we have excelled for a number of years. As I mentioned earlier, we did launch a new program in 2011. We hired a company called "Core Care National" to help us implement a sleep diagnostic and therapy management program. This program includes a prior authorization on sleep studies, and also a redirection of sleep studies with facilities to the homes anywhere appropriate. As a result, we are seeing a significant downward trend in the utilization of these services.

In addition, we continue to work very hard to reduce pharmacy trend. We have introduced in the last year a new four-tier pharmacy benefit that allows members to receive certain generic drugs and even lower

co-payment than has historically been provided.

Looking in the provider payment space, in 2012 and beyond, Harvard Pilgrim will continue to collaborate with provider groups to move in the direction of global payments. Our philosophy has been to meet providers where they are, in terms of readiness to accept risks. And, we have variety of contracting and risk-sharing models that we make available to our network. Harvard Pilgrim recognizes that we not only need to change how we pay providers, we also need to work with them more collaboratively to support them in delivering better care at a lower cost. To that end, Harvard Pilgrim has launched four provider payment -- four provider pilot models that we're launching throughout our three-state service area. And, I'll talk about these now.

The first is a Primary Care Center of Excellence Program. This is the next generation primary care-based delivery model that seeks to reduce fragmentation, improve care and coordination outcomes through the use of personal physician and leveraging the care delivery teams, as well as promoting health information technology.

The second pilot is a Specialist Medical Home pilot. This pilot seeks to improve care coordination

and improve outcomes in cases where the members are receiving the majority of their care from a specialist, such as a cardiologist or oncologist. One of the things that we've discovered is that when members are in that type of chronic care situation, the specialist ends up acting as the primary care physician. But specialist offices really aren't set up to do that. It sort of has happened by default. And, recognizing that we're looking at what sort of support services we can provide to those specialists, so that they can act as a medical home, and that makes the most sense in the patient's situation.

The third group of pilots that we're running are around global case rates for procedures. This model involves paying a global fee to a provider system to include all aspects of care centered around a common procedure, such as total joint replacement or coronary artery bypass graph, while credentially including a warranty covering avoidable complications.

The last care model that we are piloting with the network is a complex condition management program. This model involves innovative approaches for collaborating with physicians to improve quality and reduce costs for complex conditions, such as congestive heart failure or cancer, where there may be a significant

degree of unnecessary expenditures.

While these pilot models here are encouraging, we should also note that the number of physicians in our network who participate in these programs, as well as who participate in our capitation and shared savings programs, represent only a little bit more than a quarter of our provider network here in New Hampshire. That's a lower rate than what we're actually seeing, for example, right now in Massachusetts, where we have about 60 percent of the network in risk arrangements. And, part of that has to do with the fact that we have more small provider practices here in New Hampshire. And, there are barriers to getting small provider practices to adopt risk models, to adopt new care delivery models. And, that's something that we continue to work on here in New Hampshire.

The fourth question was "the extent to which we're providing commercial members transparency in terms of the cost and quality of services on network providers?" We have long been a proponent of transparency. We've worked closely with the Department since the launch of the All Payer Claims Database. And, we've done that in the other states in which we operate.

In terms of what we make available

directly to our own members, we do have some basic cost information available on our website to members to help them make choices particularly around services that are subject to a deductible. It's an area where we have more work to do to bring better information to our members. And, we'll be launching new tools in the next year or so that will be more robust in that space. We also have a section of our website that does provide quality information, both general quality information and quality information specific to the providers in the network, including information about Harvard Pilgrim's Physician and Hospital Honor Roll that's on our website to help members make better choices.

The fifth question was about "cost of coverage mandates impacted since 2006". If we look at this, the total impact of these mandates, state mandates has been about 1 percent. As was mentioned in Anthem's testimony, we have not yet fully seen the impact of the autism mandate at this point in time. So, that's one that we continue to look at carefully.

In addition to those mandates, during the same period of time there were additional federal mandates that have come into play, particularly those under the Affordable Care Act. And, those have also added

about a point or two to premium since 2010.

The final question that the Department asked about was about "premium rebates". Harvard Pilgrim did not pay any premium rebates in New Hampshire in 2011.

That concludes my testimony. I'd be happy to answer any questions the Department may have.

CMSR. SEVIGNY: Great. Thank you very much for your testimony this morning. I don't have any questions at this time, but I'll open it to staff and to our --

MR. BRANNEN: I do. You talked a bit about unit cost I think being your primary driver, in terms of overall premium growth. But that they were less, if I understood, than you expected.

MR. GRAHAM: Yes.

MR. BRANNEN: What did you observe?

MR. GRAHAM: So, this is a, I would say, a good news, but not perfect news story. So, I think Peter has the actual trend numbers. But those numbers have started to, while they are higher, they have started to come down.

MR. HORMAN: Yes. And, like, in the past years, unit cost has been as high as seven or eight percent, and it's coming down gradually to the four

or five percent. And, on the drugs -- that's on the provider side. On the drug side, too, a lot of the drugs have been moving to generic, which has given some alleviation to the drug costs. Our one concern on drugs is that, as we get more generics, manufacturers are increasing a little bit their manufacture costs. So, that's something to watch.

MR. BRANNEN: As a follow-up, you mentioned a bit about cost shifting and impact on your rates and such. I just wonder what evidence then you're looking through to support that statement?

MR. HORMAN: There was a Norton report, that was a report in New Hampshire that we've used. Some of the evidence is just from the contracting table, you know, some of the arguments we get back from providers as to what their costs are. But some of it is also, if you look at the increases in provider payment rates from the government agencies, they're public information and they're significantly lower than the increases we're seeing in the increases in costs. So, just knowing that those payers are about 50 percent of the system, that means every 1 percent they're paying under the increase in cost comes back to the commercial carriers to cover those costs.

MR. BRANNEN: Thanks.
CMSR. SEVIGNY: Okay. Other questions from staff or our consultants?
MR. CAMIRE: I have a couple, couple of questions. You talked about your -- the new tiered network products that you're offering. I think you said that two new programs started in 2010, was that right?
MR. GRAHAM: So, we launched the ChoiceNet product, first became available to customers in 2011. The Hospital Prefer product is just launching now. And, the Tandem Program first became available in 2011.
MR. CAMIRE: Okay. So, in 2011, at least a couple of these programs launched?
MR. GRAHAM: Yes.
MR. CAMIRE: Relative to expectations, have you seen a lot of enrollment? I'm assuming you have other programs that are not tiered, like your --
MR. GRAHAM: Yes. We continue to -- the majority of our business in New Hampshire continues to be in products other than ChoiceNet and Hospital Prefer. In terms of a new product launch, I think it is typical for there to be sort of a slow uptake at the beginning. And, then, as the product becomes more accepted in the marketplace, it starts to take off. We have -- I think

the enrollment expectations we had at the beginning have been met to date, and consistent with that sort of slow at first, and then, you know, we continue to expect to see growth in the product as we move forward. It does, certainly has within those groups that have purchased the product, it certainly does change the conversation that folks have.

MR. CAMIRE: In terms of the tiering of the providers, you mentioned that it's -- there's, obviously, a cost component, as well as a quality component. Could you speak to how the quality comes into the equation, in terms of, you know, how much of a factor that is, and in terms of putting the providers in different tiers?

MR. GRAHAM: Sure. So, the way the product -- the tiering is done is that we look at both cost and quality. There is, using nationally accepted quality measures, and we can get you the actual methodology, there is a quality gate. And, in order for a provider to be eligible for consideration to be in the lowest cost sharing tier, irrespective of their actual cost, they must pass the quality gate. So, if we had a very low cost provider, but that provider did not pass the quality gate, they would not be eligible to be a Tier 1

provider, and that's where quality comes into play. And, then, the remainder of the tiering is based on the cost.

So, for hospitals, we're looking at the relative unit cost between hospitals. And, physician groups, we're looking at total medical expenditures associated with members who have a PCP through that group.

MR. CAMIRE: And, one last question. Relative to other markets outside of New Hampshire that Harvard Pilgrim does business in, can you speak to the relative cost differences between New Hampshire and other markets and what you might attribute that to?

MR. GRAHAM: So, I'm going to defer to Peter to just talk about what we're seeing in terms of trend in the market, because I believe we are seeing some differences between here and Massachusetts.

MR. HORMAN: Sure. It's a hard analysis, first of all, because there's a different product mix in the two states, at least we have experience in. But, you know, I've come to believe that I think New Hampshire is higher, you know, of our three states. And, you know, and anecdotal evidence to that is, you know, we've had tiered products for a long time. And, initially, some of the mentality was to exclude some of the Massachusetts teaching hospitals from those products.

As years passed, we find that, you know, we might want those hospitals back in some of these programs, because they're actually lower cost than some of the New Hampshire hospitals. But, you know, I think -- I think New Hampshire is costlier, both because of the utilization has been so high over the past couple of years, and unit cost. And, to Bill's point, New Hampshire was trending close to two, three percent higher than Massachusetts at some points. Our Maine block is smaller, we don't have -- we have a lot of fluctuation.

MR. CAMIRE: Thanks.

CMSR. SEVIGNY: Any other questions?

MR. BRANNEN: Yeah. Can you talk a little bit about buy-down, what you observed? You mentioned it, but you didn't give us any rates.

MR. GRAHAM: Do you have any specifics on buy-down, Pete?

MR. HORMAN: Buy-down. Typically, I've seen, in larger groups, buy-down offsets the aging increase, so that the account tends to get a peer trend increase. So, if the aging has been two percent, buy-down on larger groups is about two percent. Small group market, it's been much higher. And, that is to get price relief, I think. So, you know, the ten percent that

Anthem quoted isn't unrealistic.

MR. GRAHAM: And, I think the other thing that we've observed in this space, again, drawing comparisons between states, is the rate of buy-down in New Hampshire has been more significant than is the case in Massachusetts. We have groups in New Hampshire who have purchased plans with much higher deductibles and other out-of-pocket cost sharing than we have seen in Massachusetts. We have a much higher percent of our bookend deductible products than in Massachusetts.

CMSR. SEVIGNY: Good. Thank you very much, Bill and Peter.

MR. GRAHAM: Thank you.

CMSR. SEVIGNY: Next, I'll call on MVP Health Insurance Company of New Hampshire please.

MR. LOPATKA: Thank you for the opportunity to testify this morning. My name is Pete Lopatka. I'm a Vice President and Chief Actuary at MVP Health Care. MVP was founded in 1983, a community-focused, not-for-profit health insurer, serving members in New York, Vermont, and New Hampshire. Through its subsidiaries, MVP provides fully-insured and self-funded employer health benefits plans, including dental, ancillary products, such as free --

flexible-spending accounts, to more than 650,000 members, but, in New Hampshire, we are currently at 11,000 membership.

In response to an August 23rd letter from the Insurance Department, MVP has supplied to regulators specific data and information requested on health care costs and premium rates in New Hampshire. I will address the six questions posed in the letter this morning.

On the first question, asked about the "primary drivers of unit cost, utilization and mix assumptions used in the 2011 premium development". And, by -- broken up by unit cost and utilization, those were, on inpatient, 6.3 unit cost; outpatient, 6.3 unit cost; physician, 4.4 unit cost; pharmacy, 4.7 unit cost. And, the utilization by those four major service categories: 2.0, for inpatient; 3.0, outpatient; 3.5, physician; 1.0 utilization. Those were the assumptions used in the development of the 2011 premiums.

The second question addressed what was the actual -- having the ability to go back, "what was the actual experience trends from 2010 to 2011?" Again, those same four major categories: The unit cost came in at 5.2 for inpatient; outpatient facility, 5.7; physician, 4.7;

pharmacy, 2.5. And, on the utilization side, on hospital inpatient was minus 6 for utilization; 0.7 for outpatient utilization; minus 1.6, physician utilization; and 1.5 for pharmacy. So, we were in line with unit cost expectations of around five or six percent, but the utilization levels came in below expectations.

In addition to what's happening in the broader economic conditions, you know, where demand is going down, I'd caution the Department as it's reviewing these that our -- the dramatic change in membership during this period. We had 26,000 average members in 2010. And, by the end of 2011, we had 14,000. So, it's -- although we do our best to adjust for -- make sure it's the same health risk profile in both periods, it's difficult to do when you have that kind of disruption in membership.

The third question asked that MVP "identify any changes or innovations that have been implemented since 2010 in product design, medical management, and provider payment models." For products, we've introduced EPOs and subjected more benefits to a higher deductible. These are non-qualified, now higher deductible plans, in an effort to get a lower price point by having more cost share. Also, for qualified high deductibles, after the deductible is met, add copays

instead of coinsurance after, so the cost sharing continues throughout the whole life cycle of the plan. And, also introduce AlterNet schedules, where there's a lower member cost share when using a freestanding facility.

On medical management, in 2010, MVP hired Dr. Allen Hinkle to lead the organization's enterprise-wide efforts to control medical costs. He has a program that's in place that addresses contracting, claims editing, outpatient/ambulatory services, emergency services, hospital discharge quality and others throughout the organization, and that's region-specific. And, there's -- all projects seek to provide cost savings, and while maintaining the quality of care that they provide.

On provider payment models, MVP is exploring innovative opportunities to change the provider reimbursement model.

Question 4, "the extent to which MVP is providing commercial members transparency in terms of cost and quality?" We strive towards transparency of information for our members, but barriers in the current marketplace and capital investments do make this difficult. We agree with the importance of increasing transparency and disclosure in this area and fully support

any public or private sector efforts towards this end.

Question 5 asks about the "cost of mandates since 2006". And, given limited resources, we were not able to go back and exactly quantify what the cost of those mandates were or how they met our expectations for what they would be. There's no question that they increase cost. It's how much is what's unknown for MVP. Mandates, however, I'd like to note, are only one of many factors that are driving health care costs and premiums.

And, Question 6, "did MVP pay any premium rebates in 2012, based on 2011 performance?" No, we did not.

So, thank you for your time, and welcome any questions.

CMSR. SEVIGNY: Great. Thank you, Peter. Let me open it up to Department staff for any questions for MVP? Jen.

MS. PATTERSON: Can you give us any detail on your provider payment innovations?

MR. LOPATKA: Not at this point. But it's -- other than it is -- it's top of mind. You know, that's something that we see our unit cost position, there's a report that the Department had put out, we know

that it's not competitive right now and it needs to be addressed.

MS. PATTERSON: Thank you.

CMSR. SEVIGNY: Questions from any of the consultants?

MR. BRANNEN: Actually, if I could just, as a follow-up on that. What do you think is the greatest barrier to MVP implementing payment reform that is meaningful? I mean, is it small -- is it low membership count? Is it something else that creates a problem?

MR. LOPATKA: I would say low membership count. In terms of, you know, when you're talking about "payment reform", whether it's -- you can approach that from the private sector or the carrier being able to do that, and what their responsibilities are, what they can do, they can only do what they have in terms of leverage from members. And, then, there's what the state can do or what the Department can do. And, as we see in states in the area, we see a lot of activity with the -- the state is coming in doing the payment reform, rather than leaving it up to the carriers to find a better way.

So, you need -- So, the answer to your question, yeah, we need volume to be able to drive payment reform. If you don't have volume, if you don't have

leverage, then you don't drive payment reform.

CMSR. SEVIGNY: Bela.

MS. GORMAN: Thanks. Similar question we asked Harvard Pilgrim. Can you speak to the price differences between your New Hampshire market, I know MVP is in New York and in Vermont, can you speak to or give us any insight as to that?

MR. LOPATKA: The short answer is "no". We haven't done a -- like a detailed analysis. As Harvard has indicated, that's a complicated exercise. To determine what cost differences are appropriately addressed, adjusting for cost of living, and there's demographic mixes and all that. And, we have not done that, to compare New Hampshire to our other two states.

MS. GORMAN: And, just a follow-up. You had mentioned that there was a big membership drop in this past year?

MR. LOPATKA: Yes.

MS. GORMAN: Could you give us some of the biggest contributors as to why that happened?

MR. LOPATKA: Yes. We had to increase our rates substantially.

CMSR. SEVIGNY: Any other questions? Jen.

MS. PATTERSON: Again, on the provider payment issue, in any of the other states where you operate, maybe where the state has been more involved, has there been anything that's been effective, in your opinion, on that issue?

MR. LOPATKA: Yes. We do, in Vermont.

MS. PATTERSON: Good.

MR. LOPATKA: We have the Northern Vermont Significant Risk Share Arrangement there, where all of our business goes through that risk share, which is global cap, where the surplus and deficit is shared, like 100 percent up to a quarter. So, it's not -- whenever you talk about risk shares, there's always a continuum of maybe some -- a soft, I'll call it a softer kind of gain share. Whereas, maybe if there's some profits, you get some money back. And, all the way to the other end of the continuum, which is, if you're in it together, you share losses and profits. And, it's a significant share in northern Vermont. And, which does reflect across the footprint of MVP our -- kind of our most competitive region.

MS. PATTERSON: Thanks.

CMSR. SEVIGNY: Any other questions? Good. Thank you, Peter. Next, I'd like to ask Cigna

HealthCare of New Hampshire to come up and speak with us.

MR. GILLESPIE: Good morning, Commissioner, staff, consultants. I'm going to have -- Trey and I, we're going to tag team today. So, thank you for giving us the opportunity to present today. I'm Pat Gillespie, Director of State Government Affairs for Cigna. In my role at Cigna, I represent the company before executive branch agencies, state legislators -- state legislatures, excuse me, across a ten-state region, which includes New Hampshire. Prior to joining Cigna a year and a half ago, I spent 17 years working for the State of New Jersey, please don't hold that against me. And, I was a district director for a U.S. House member, who considers himself one of the architects of the Affordable Care Act, again, please don't hold that against me either.

With me today is Trey Swacker. Trey is an Actuarial Director for Cigna. He's been with the company for ten years. And, he is the lead for medical pricing for the Northeast region. Our territories overlap in the Northeast.

So, just a word about Cigna. We're a global health service company headquartered in Bloomfield, Connecticut. Our core mission is to improve the health, well-being, and financial security of the people that we

serve. We have 70 million customer relationships across the world. We do business in all 50 states. We do business in 30 foreign countries. We have about 35,000 employees worldwide. Our business model is focused around going deep to serve the needs of our individual customers. We go deep to engage them to help manage their own health and to manage their access to health care services, and to make it easier for them. We're also expanding into new markets abroad, with India and Turkey coming in the near term.

So, our motto is to "Go individual, go deep, and go global." Some of you might also have seen our rebranding campaign. We have the new tree. And, you might have seen the "GO YOU" ads, which are running on CNN and other national cable networks. The first two questions, Commissioner, dealt with unit cost and utilization. So, I'm going to ask Trey to answer those two on our behalf.

MR. SWACKER: Hi. Thank you. With respect to the first question, "primary drivers of unit cost, util., and mix assumptions used in the 2011 premium development". For unit cost, we typically model the expected rate increases with contracted physicians and hospital systems, using a fixed basic of goods, and

generally project that pretty tight. For utilization and mix of service, we look broader than just the New Hampshire market, because these two components are more volatile. For utilization, we set our trend assumptions at the low end of historical averages. We saw a significant drop-off in utilization trends beginning in 2010. So, we didn't set our 2011 expectations to this level, but at the low end of what we had seen in the '07, '08, and '09 period.

Moving on to the second question, "what did we actually experience?" Again, unit cost was largely in line with our expectations, in the mid single digit range. Utilization and mix of service did come in favorable overall. Overall trend was about a point and a half better than our pricing expectation in New Hampshire, more driven by the combination of utilization and mix. We saw a lower than expected utilization with outpatient services and with prescription drugs. We did model a lower prescription drug trend, given the line of brand new drugs coming off patents. But we did see a quicker adoption of generics that are ramped up than sort of our modeling had predicted. So, that contributed to some favorability. Within inpatient, we actually did see slightly higher utilization in New Hampshire. Nationally,

we saw low inpatient trends. So, it could be more of a mix issue.

MR. GILLESPIE: Thanks, Trey. For Questions 3, (a), (b), and (c), "what changes or innovations have been implemented since 2010?" I'm going to skip 3(a) for now, and answer it when I get to Number 4. With respect to Item (b), which is our medical manage -- medical management programs, Cigna has had a Your Health First Program since 1997. And, beginning in 2011, and continuing into this year, we're running into the next generation of the Your Health First Program. Again, going deep. We view it as a way to stop our customers and patients from manufacturing diseases; obesity, diabetes, tobacco-related diseases. The Your Health First Program provides health coaches to customers with chronic conditions, 16 current conditions, asthma, heart disease, COPD, and it pairs these customers, these patients, with a dedicated health advocate, who's going to coach, prod, and pester. And, I can tell you, from going to meet with customers, I've actually had them complain and tell me "Please have my health coach stop calling me", but that's their job. They're designed to provide holistic support to the patient, get them to adhere to their medications, manage their risk factors, support them in lifestyle

choices, and also, when they're seeking treatment, help assist them in treatment decisions.

The newer version of the Your Health First Program that we're rolling out now is going to cast a wider net. And, not only to engage patients who are considered at high risk, this program is designed to engage patients who are lower down on the risk pyramid, those that you might consider "moderate risk". And, the idea is to get to them early, to try and yield long-term savings, and have long-term health benefits. Look at things like BMI, cholesterol, tobacco use, again, try and get to them early before they become a chronic case.

Our current program, we serve seven and a half million people nationwide, and we've driven 250 million in medical cost savings nationwide under the Your Health First Program. One of the new features of this next iteration that we're working on now is to use CEO and corporate leadership as part of an overall communication strategy to drive greater client engagement, greater customer engagement among the firms. We're also going to pair this program with plan designs, with consumer-directed features, minimum cost-sharing requirements, provide engagement incentives or disincentives to folks, and also outcome incentives,

again, working with the employers, provide outcome incentives on either smoking cessation or BMI or those sorts of things.

The current program, we've saved three percent on total medical costs, this is nationwide. We found that 71 percent of the individuals who actually engaged with us met their goals. And, that 90 percent of the cardiac customers who are involved in this program were adhered to a beta blocker after a heart attack.

With respect to provider payment methods, the collaborative accountable care, which is Cigna's brand and model for accountable care, organizations in accountable care agreements, got its start here in New Hampshire with Dartmouth Hitchcock in 2008, something that we're very proud of. New Hampshire is not only the leader here in New England, but the leader nationwide for Cigna in this process.

In 2012, we recently announced we have an agreement with the Granite Health Network, the five Granite hospitals. We just announced a partnership with them this year. Overall, I think as folks know, the Collaborative Accountable Cares are designed to expand patient access to health care to improve care coordination. We also view it as a way to improve on a

triple aim of benefits to improve healthy outcomes, lower medical costs, and most of all -- or, excuse me, and, importantly as well, to increase patient satisfaction with their health care. We believe that this new Granite Health Network, the G5 arrangement, is the largest in New Hampshire between -- with doctors and hospitals in a single plan, 23,000 patients, with 900 Granite Health Network doctors. It's available on all our products.

The basic model again, I think as was mentioned before by some of the other carriers, evaluates the organization on costs and quality. Groups are evaluated based on their adherence to evidence-based models, and must achieve benchmarks compared to their peers or control group. Then, depending on meeting those benchmarks, the total medical cost is looked at on a year-to-year basis, again, evaluating against their peers. And, if the group's total medical cost and the quality measures, if that -- if the quality is higher, the trend is lower, then the organizations they -- excuse me, is eligible for a gain share, which is negotiated at the start of the agreement.

One of the critical features of our collaborative accountable care model is the registered nurses, who serve as our clinical care coordinators. We

provide the practices and the physician groups involved with actionable data, that the RNs then use to engage the customers, engage the patients. The idea, again, is to close gaps in care, with adherence to medications, follow-up visits, refer to other clinical programs. Nationwide, Cigna has 32 of these agreements in place in 17 states, nationwide, over 270,000 Cigna customers and 4,000 doctors are involved, again, nationwide in these programs. For us, New England is, by far, the most active region for collaborative accountable care, and New Hampshire is leading the way.

With respect to Question 4 and 3(a), again, we've had an existing program called the "Cigna Care Network", the Cigna Care Designation Program, and we've gone deeper into this program to help our individual customers. If you look on our provider directories, you see a little symbol, kind of a tree branch. That signal means -- that symbol means that the doctor was reviewed for both cost and quality, and that they made the designation as part of the Cigna Care Network.

Since 2006, here in New Hampshire, we've had Cigna Care Network products approved for the fully insured products, we also provide them to our ASO, our self-funded customers. With these products, employers can

choose benefit plan designs, which provide lower co-pays and co-insurance, when seeing someone with the Cigna Care designation. It's not a lock-in, but it is a tiered plan designed to steer you to certain providers.

Starting in 2013, again, going deeper, we've now included primary care physicians into this program, whereas previously it was limited to specialists. We've also established a process, peer groups to review doctors based on their specialty in zip codes so customers can make apples-to-apples comparisons. We've worked with NCQA on this new process, we use their review program, as well as an indicator, as well as HETA scores, Leapfrog, and CMS quality measures. We have implemented a new process that's slightly more rigorous with respect to cost. We've also implemented for specialists a tie-in with our Center of Excellence Program, with our hospitals who are rated Centers of Excellence. And, we're rolling out this new Cigna Care Network in 2013. Physicians were given notice in June of whether they qualified. And, we're now going through an appeal process. And, as I said, the program will be live 01/01/2013.

Questions 5 and 6 I'm going to hand back off to Trey.

MR. SWACKER: Thanks. Question 5, the

"cost of mandates passed since 2006". For what we can quantify, there were some mandates that were already included in Cigna's standards of coverage. But, for the ones that added to coverage or represented a buy-up, approximately two and a half percent of claims is our estimate for the cost of that coverage. And, again, in terms of an ongoing analysis of mandates, it is included in the total medical claims that we review for rate review, so don't now how each individual mandate is performing relative to the pricing expectation. However, we have done some national studies, or for states with similar mandates, to reevaluate "are we charging an appropriate price?"

An example of a mandate that is performing favorably is bariatric surgery. It really I think added about a point or so for coverage of that mandate. And, I think that's experience coming in variable by a few tenths of a point there. So, we are adjusting that in our pricing, and is -- will be swept into overall rate decreases or changes that we're filing in New Hampshire and other states.

To the last question, "did we pay a rebate in New Hampshire based on 2011 performance?" Yes, we did pay a modest rebate. Our impact on loss ratio was

84.9 percent in New Hampshire, which represented a rebate of $77,000, that tenth of a point of premium, for approximately 16,000 covered lives.

So, with that, we'll take any questions from the Department.

CMSR. SEVIGNY: Great. Thank you very much. Let me open it up to staff for any questions of Cigna?

MR. BRANNEN: A question about your ACO contracting, I guess. The first question is, is it the same model that you're using for your self-funded and your fully insured? And, Question Number 2, what savings are you associating with the ACO models you're using?

MR. GILLESPIE: We're using it for the same products. So, yes. It's the same for fully insured, the same for self-funded. And, I don't know if you want to answer the cost?

MR. SWACKER: Right. Yes. In terms of the cost, we aren't changing the underlying fee schedule or the fee-for-service reimbursements to the providers, but we do pay a care coordination fee. And, there is upside to that. If they beat on quality metrics, as well as market trends, there's a percent of savings that we'll share through an increased care coordination fee. In

future years, if the ACO doesn't perform better than market trends than the quality metrics that are cast in here, we can reduce that, although it doesn't go negative. So, the base fee schedule or rate of increases is the floor for the ACO model.

So, I think, with the G5 again, too soon to tell, because that's just been rolled out this past July. With Dartmouth, I think, over the past four years, some years have beaten trends, some years haven't. But, overall, I think it's been a net increase. It's been equal to or potentially lower savings. But that would come both through the fee-for-service contracting, as well as the risk-share payments.

MR. BRANNEN: So, the trend is basically the control group, and that's what you're saying would have taken place without the ACO model, is that correct?

MR. SWACKER: What --

MR. BRANNEN: I'm saying, when you're comparing the group comparisons to trend, is that essentially your control group? So, any savings from that trend you're associating with the ACO model, is that correct?

MR. SWACKER: Right. Well, we're -- so, we're comparing the market trend, which would be New

Hampshire market or whatever applicable geographic area, to the trend of the attributive members in the ACO model to see if they're trending at a lower rate. But there's also, are they closing gaps in care and other quality-based metrics that, when combined, would trigger an increase in the fees that are issuing that we pay.

MR. BRANNEN: And, you said it's too early to tell in New Hampshire. Do you have statistics from other parts of the country?

MR. SWACKER: For the G5 arrangement in New Hampshire, just because it's new. Again, Dartmouth, we've been a partner with for I think four years now. And, again, as I said, some years they beat trends, some years they didn't. So, that's reflected in both the risk-share payments, if it's gone up or been pulled back, as well as just the underlying fee-for-service negotiations. And, then, nationally, again, we've seen some success where we're beating trend in the market, but not involve the 17 or 30 ACOs that are up and running, not all have beaten the market trend.

So, again, still in the early stages. And, Dartmouth was our first ACO arrangement in '08. So, all the others have been started, the majority, in the last year or two, a couple in 2009.

MR. BRANNEN: Thanks. And, for the folks on the phone, we're getting some feedback. If you can check to make sure your phone is on mute, we'd appreciate it. Thanks.

CMSR. SEVIGNY: Questions?

MR. WILKEY: Yes. How is the impact of outsourcing, what I call "outsourcing" of ancillary services impacted your cost structure and the trends here in New Hampshire and what you see around the country, for example, PT services and chiro services?

MR. SWACKER: Outsourcing to the vendor programs that we've entered --

MR. GILLESPIE: Yes. Our third party vendor arrangements.

MR. WILKEY: Right.

MR. GILLESPIE: Again, we do contract with third party vendors for a variety of services; PT is one, chiropractic. And, again, these are normally nationwide deals, that we try and have this tailored, obviously, to the regulatory framework in each state. A lot of them are new that we just rolled out. So, I'm not sure if offhand I can give you an exact answer in terms of the trend. And, again, we would be basing it nationwide, in terms of our total spend, understanding that, again,

regulatory framework within each state may not allow us to implement the contract the way that we would someplace else.

So, Trey, I don't know if you have a figure now. But, we can -- if you'd like, we can try and supplement our answer, Mike, and get back to you with that.

MR. WILKEY: Thank you.

CMSR. SEVIGNY: Any other questions?

MS. SMAGULA: Just one last question. If there's any comments, similar to what we asked the other carriers, that you can provide, as far as how New Hampshire costs compare to other states you're in?

MR. GILLESPIE: Well, New Hampshire, while it is a high-cost state, I cover ten states, starting in Ohio and moving up to Maine. The one thing that we don't see here in New Hampshire, thank, God, is high out-of-network utilization and high out-of-network costs. And, for those of us that cover downstate New York and New Jersey, it is a cancer on the marketplace. There are providers who are engaging in entire out-of-network business models, driving utilization entirely through their emergency room. They charge, for certain procedures, 1,000 percent of Medicare. They're involved

in all sorts of dodgy ways to get folks, like I said, into their ERs. And, for some carriers, out-of-network utilization can be as high as 30 percent of their total medical spend. And, when I tell you it's a serious problem in New York and New Jersey, downstate New York more than, certainly, a lot more than upstate, it is a huge issue. Not something that we see here in New England, or in Pennsylvania or Ohio or the other markets that I cover, thankfully. So, --

MS. SMAGULA: Uh-huh.

MR. GILLESPIE: And, there's a variety of public policy reasons, assignment of benefits, you know, for a certificate of need process in those individual states. Routine waiver of cost sharing, which Medicare defines as "fraud", is rampant in New York and New Jersey.

MS. SMAGULA: Uh-huh.

MR. GILLESPIE: So, there's lots of different policy reasons for that. And, even though New Hampshire is an expensive market, it could be worse.

CMSR. SEVIGNY: Okay. Well, thank you very much for coming up this morning. Let me ask Steve. Do you need a little bit of a break or anything? We've got three other witnesses.

MR. PATNAUDE: Three other? We could take a short break. That would be great.

CMSR. SEVIGNY: Okay. Why don't we take -- let's take five minutes and no more, so we can continue on, okay? Thank you.

(Whereupon a recess was taken at 11:23 a.m. and the hearing resumed at 11:33 a.m.)

CMSR. SEVIGNY: Okay, if we could reconvene, and bring the hearing back to order. Our next witness this morning is the New Hampshire Health Plan. And, for that, I'd like to ask Mike Degnan to please address us.

MR. DEGNAN: Thank you, Commissioner. I'll be very brief here. Let me just do an overview of the New Hampshire Health Plan and the programs we offer, and then I'll respond to question that we received from the Gorman Group. New Hampshire Health Plan, we offer two insurance programs for the folks in the individual market. They are the State high risk pool and the federal Pre-existing Condition Insurance Program, the PCIP Program, which was one of the first initiatives in the Accountable Care Act. We are governed by a 11-person board. We are a not-for-profit voluntary organization

established by the state under Chapter -- RSA Chapter 404-G. And, our Board is made up of -- we have six -- eleven people on the Board. We have six carriers, and then we have representatives from the -- a consumer representative, a provider representative, a small employer representative, and a producer representative, along with Dave Sky, from the Insurance Department, is a non-voting member.

So, let me talk about the State program for a moment. The State program was initiated in 2002, and today we serve 2,900 New Hampshire citizens. We have three sources of funds there. They are the -- we have carrier assessments, premiums, and federal grants. Our budget for 2012 for the State program is $24.5 million, and, in 2013, our budget will be close to 40 million. Our assessment in 2012 is $1.49 PMPM, and those assessment fees are built into the carrier costs.

A little bit about, as I said, we have 2,900 enrollees. We've had an 11 percent increase in enrollment in 2012, compared to a 51 percent increase in enrollment in 2011. So, there's been -- we've had a huge increase in the last couple of years. But our loss ratio in the State program is 163 percent, which is better than it has been in the past.

In the State program, we offer seven benefit plans. These plans reflect the offerings that exist in the individual market. And, in fact, annually we assess the product offerings and adjust our products based on the market needs. We have leased networks for both pharmacy services and clinical services. Our provider network is First Health/Coventry, and our pharmacy network is Restat, which is administered by the Pharmacy Network of Kansas. And, we have our own individual network that we've developed over the last four or five years that gets better discounts than Coventry does. We have contracts with 14 of the hospitals here in the state.

Our rate setting process is set by statute. We analyze the carry policies offered in the individual market and calculate the standard risk rate. And, once the standard risk rate is determined, we can set the rates between 125 to 150 percent. For the last five years, five to six years, the rates have been set at 125 percent of the standard risk rates. We also -- and, we set the rates on a semiannual basis. And, we also offer a Low Income Premium Subsidy Program that has subsidies of up to 20 percent discounts, depending on the resources of the individual at the time of enrollment.

So, let me talk about the PCIP program

for a moment. We were the first state in the nation to sign a contract for the program. We had the first enrollee. We started in July 1st of 2010. And, we've spent more money than most states. We have had an allocation of $20 million for the three and a half years of the program, that's through run out. We spent the $20 million by the second quarter of 2002 **[**2012**?]**. We requested $50.3 million for 2012, and received that. And, we're currently in negotiations for 2013 through the run out, and right now we're asking for an additional $70 million for that program. So, we will be, if, in fact, they choose to continue the relationship with the New Hampshire Health Plan, the budget for the PCIP program, in 2013, will be $75 million. So, NHHP will be managing about $115 million in 2013, depending on some negotiations.

We currently have 592 individuals enrolled in the New Hampshire PCIP program. Our medical loss ration is about is 1,200 percent. So, we're doing a wonderful job spending money.

I think the key issue right now is, we're negotiating with the Center for Consumer Information & Insurance Oversight for 2013 to 2015. We'll know within the next month if we are going to continue to be the

administrator for the program. This program is 100 percent federal funded. No state dollars are involved in the PCIP program. And, so, we'll have to see what develops here in the next months or so. I think these programs have been incredibly successful for the citizens of New Hampshire. The PCIP program is -- we allow third party payment of premiums in that program, which has significantly contributed to the costs. And, we think that we -- our goal is to continue that through 2013.

The interesting thing about New Hampshire Health Plan is we'll be going out of business at the end of 2013. So, I think there's a discussion going on at the Board level right now about what the future might be for us. Do we continue to have those people who are currently enrolled in the State program? Do we allow them to stay enrolled? And, Gorman Associates has done some study on that, and our Board will be meeting next week to discuss that issue.

So, as it relates to the six questions that we received relative to the submittal here, I think it's pretty straightforward from our perspective. The first question is, "how would you respond to the theory that some carriers provide network strategies that may be in conflict with hospital or provider groups, that is site

of service strategies?" That doesn't really affect the New Hampshire -- the New Hampshire Health Plan right now. I think our goal is to strike a balance between service for the patients and cost-effective management. So, that's what we're doing now.

And, they wanted to know, Question 2 is "to what extent does your 2011-12 commercial product contracts include incentives?" We have none at all. We are purely a fee-for-service the way we operate.

What -- Number 3 is, "what member engagement initiatives have you undertaken in 2011 and '12?" We do have a Disease Management Program. We work with a vendor, Medical Cost Management, out of Chicago, Illinois. Frankly, I've been disappointed with some of the disease management results that we have seen. And, we're continuing to evaluate the worthiness of that program.

"What new strategies for 2012 and beyond are you going to employ to control health care costs?" First of all, we try to take a look at what the assessment -- the product offerings we have in the marketplace. We do that, we call it a "product refresh", on an annualized basis. And, as we look at 2013, we'll probably have the same product offerings as we had in 2012.

I mentioned the Disease Management Program and case management that we have. And, third, we have been working, as I said, to improve our network discounts. And, we've been working with the providers to try to do that here in New Hampshire.

Top challenges for us? Timing is a challenge. We don't really have much of an opportunity to have an impact on our costs with one year left in the operation of our program. And, we have low volume. We've heard the other carriers testify that you get your discounts based on volume. We have very low volume, especially in the PCIP program.

So, all in all, I think NHHP has been a great benefit to the citizens of New Hampshire. And, we hope to, you know, I think we'll have a strategic discussion about where we go from here.

CMSR. SEVIGNY: Thank you, Mike. Any questions from Staff? Consultants? Thank you very much, Mike.

MR. CAMIRE: I just have one quickie.

CMSR. SEVIGNY: Okay.

MR. CAMIRE: You mentioned a huge growth in membership that you saw over the last couple of years.

MR. DEGNAN: Right.

MR. CAMIRE: Other than the onboarding of the PCIP program, was there any other item that you could point to that raised the --

MR. DEGNAN: One in particular. We had a closure of a plant in northern New Hampshire we worked with the Department on, there was a couple of hundred individuals who became eligible for the program through the HCTC plan. So, with the assistance of the Department, we signed up a substantial amount of those. So, I think that was a key factor.

And, I think the other thing that has occurred, with the consumers' understanding of what's going on with insurance and Accountable Care Act, but more awareness of our program I think came into effect. So, those two factors, I think, really have contributed to help our enrollment. Our enrollment in 2007 was less than a thousand people in the State program.

MR. SKY: Can I just follow up --

MR. DEGNAN: Absolutely, David.

MR. SKY: -- to expound a bit? One of the things that startled me, is that looking at membership, changes for the State High Risk Board, is that there seem to be spikes around April and October, the same time we small group -- open enrollment for small groups of

one.

MR. DEGNAN: Thank you.

CMSR. SEVIGNY: Great. Thank you very much, Mike. Next, I'd like to ask Dr. John Buttery to come up and speak to us, provide us or give us the provider perspective. Dr. Buttery.

DR. BUTTERLY: Thank you very much, Commissioner. It's "Butterly".

CMSR. SEVIGNY: Oh.

DR. BUTTERLY: By the way, while I appreciate --

CMSR. SEVIGNY: I'm sorry.

DR. BUTTERLY: -- you did not say "Butterfly", which frequently happens. I tell people "the "F" is silent."

CMSR. SEVIGNY: At least I only made a half mistake.

DR. BUTTERLY: But the "L" is not, so. I thank you for the opportunity to testify. So, I'm really coming at this from a provider perspective. I'm an actively practicing cardiologist, and have been for my entire professional career. I do have certain administrative responsibilities. I was responsible for initiating and building our patient centered medical

homes, when we began our demonstration project for CMS. And, I was the lead physician for that project at the Academic Medical Center, working with my colleague in the south, Barbara Walters. And, I also went through the managed care world when I was in Massachusetts in the 1990's, and I'm seeing a lot of now of what I saw then. So, you can see in this room you've got a collection of extremely intelligent people, who are truly socially committed to making this work.

We've been working on this now, in my life, 20 years to try to correct the imbalance between quality of care, on the one hand, and cost, which we can no longer afford, and really couldn't afford then. On the other hand, it still doesn't work. So, in my world, when that happens, we change our plan, and we change it abruptly, because, obviously, we're not doing something right. And, I'm unencumbered by any real knowledge about insurance or the world a lot of you live in. So, I do see it differently. And, by the way, I'm not on our contracting group, and, I'm really not involved in this. I really am on the provider side of this.

And, one of things that I see is that people are trying very, very hard to minimize the pain that I think we know is coming. One of the first lessons

I learned in medical school was that, when you're going to recommend something to a patient or you're going to do something to a patient and it's going to hurt, do not tell them "it isn't going to hurt." And, this is going to hurt, as far as I can tell, as far as the changes that we have to go through.

So, I'll answer the questions, which are, obviously, different ones for the providers, and tell you a little bit about what Dartmouth Hitchcock is doing, and what we see from the other providers and facilities that we are working with and trying to form a truly integrated health delivery system.

Question 1 is, "to what extent are the providers or hospitals you represent pursuing new payment structures with your primary payers in bundled payments, medical homes, and ACOs?" So, we took advantage of the opportunity that a CMS demonstration project offered us in 2005, the CMS PGP, or Physician Group Practice, demonstration project, because there was upside risk only in that particular project. And, it gave us an opportunity to share in any savings, and then pay for the systems we knew we were going to need in the future. We knew this was coming, we knew we needed to pay for these systems. So, since 2005, we were involved in that

demonstration project. And, most years -- all years beat our quality gates, made the quality gates. Most years beat the cost expectations, although one year we fell below the hurdle we had to pass, which was two percent, and one year we actually spent a little more than the expectation, but, really, it was very minimal, minimally below that.

And, we did get an increased payment from CMS, to the tune of $10.5 million over that five years. That was just okay. That was just okay performance. The reason that we couldn't perform better and I'm sure there are a number of them, is that we were developing the very systems we were going to need to perform well. So, we were kind of flying blind throughout that process. However, we are working very hard to be able to accept a global budget. That's where we think we need to be. But, if we try to do that with the systems that we have now, we'll fail. We won't be able to do it well. And, it's dangerous, obviously, for the health of the system I'm representing, but it's dangerous for the patients. So, we need to be able to make a transition, from what is a fee-for-service world, into a population health management world. And, it's a very different way of thinking about it, and the data that is needed and the

measurements needed, and the actionable reports that we need are very different.

You heard what our colleagues in Anthem and Cigna and Harvard had to say, and I didn't disagree with one thing they were saying. And, we very much value the relationship we have with them. We have developed true ACO models with Anthem and Cigna, and I believe have at least had the discussions, if not actually finalized contracts with Harvard Pilgrim as well in that regard. We have over 100,000 lives now that are involved in these risk-sharing contracts. And, we are a pioneer ACO. The major difference between the pioneer ACO, the PGP demonstration project and the -- some of these clinical contracts -- commercial contracts is that there's downside risk to that as well. And, we're prepared to take that. We're prepared to take that risk, because we believe that we have the systems that's going -- that are going to enable us to perform reasonably well. That's not true of the other providers that we talk with and that we are trying to integrate with, both on the physician/nursing side and on the hospital side.

In order for us to really develop the systems we need, and for these other providers to develop the systems they need in order to perform well, we need

time, and we need the ability to share in the cost savings when they develop. I cannot -- I do not know, I don't have the personal knowledge as to where the contracts are going or where they are in the State of New Hampshire. But I do know that the people that we talk to are very, very nervous about letting go of that fee-for-service model. If you think about it, we kind of have our feet in two canoes. There's a fee-for-service canoe, and that's kind of floating away, and we have got the accountable care canoe, and at some point you've got to jump, you've got to make that decision. That transition needs to be made safely or we're going to harm providers and systems within the State of New Hampshire. And, God forbid, we should harm individuals as well. That they will lose their coverage or not get the care that they need.

You asked, "Please comment on if the providers or hospitals you represent generally have the infrastructure to manage." I think I just answered that.

"Describe the level of integration that providers or hospitals you represent have with other providers. To what extent does this integration add or subtract from the overall cost of providing care to patients?" We are integrated with other providers, with other organizations. We are trying to bring that

integration into a much more organic phase. But we learned a lesson in our negotiations with Catholic Medical Center, in Manchester. And, there was a differing opinion as to what constituted unfair competition, I guess, and that relationship didn't happen. We're sensitive to that, and sensitive to the fact that what ACA is telling us to do, and what we think is the right thing to do, which is to fully integrate, in a way that truly enables us to provide value to the population that we serve. But the FTC and the Attorney General of New Hampshire may have a differing opinion of that. And, we're very cautious about it, and want to make sure we do it correctly and legally, and that it's not controversial. We don't think that it should be.

One of the things I hear the payers saying is talking about "unit cost". "What is your unit cost? What is that doing?" From my perspective, again, as a provider, unit cost really isn't the issue, it really is the total medical cost, which I also heard discussed.

But, as a cardiologist, my -- it costs the system a thousand dollars if I recommend a cardiac catheterization, I'm making up the number, obviously, and there's another cardiologist also in the state and it only costs 800. But, if you come to see me, you're only about

10 percent likely to have that recommended, based on -- on evidence based in the literature, quality care, but I'm only going to recommend that test 10 percent of the time, and the other cardiologist is recommending it 80 percent of the time. I'm making this up to make a point. The total medical cost that that provider is giving is much higher. But, really, what's being measured now is unit cost. So, it's not entirely accurate and difficult for patients to make the right decision, because they don't have that number. And, we all need to work more towards that. That's clearly the metric for population health management.

"To what extent is your cost and quality information available?" It is available on the Internet, but, again, it's pretty much cost per unit, it is not total medical expense. And, if you look at the Dartmouth Atlas, you'll see we're very low utilizers, and always have been. It's part of our culture. But that's not really, it's measurable, but it's not reportable right now.

"How is the cost of health care impacting the providers' or hospitals' ability to provide care?" It's definitely affecting us. And, it's not just the cost to us of actually providing care, but it's

reimbursement issues as well. We're all struggling in this difficult time. We intend to survive. And, we intend to continuously improve the quality, and reduce the cost of the care we're providing this population. That's in our mission, that's what our intent is.

The final question is, "Are there provider contracting strategies in place or being proposed by carriers that are in conflict with strategies being proposed by your represented organizations?" I'm not in our contracting group. I can't really answer that. I think that there are some points of friction or tension that we have to discuss. For example, we believe, in order to do this right, and you all know you need large numbers of covered lives to be able to do this, we believe that the provider should be controlling the care management, the care coordination. Historically, I believe the plans have actually wanted to do that and have done that. But I don't think Anthem wants to pay for the care management of a Cigna patient, and vice versa. We need to be able to pool our resources to see to it that we should be blinded to who the insurer is. We have to pay attention to our patients. And, we can do that if we have that resource. But it's very difficult for us to manage if the resource doesn't belong to us.

I'll stop there. And, I'm happy to answer any questions.

CMSR. SEVIGNY: Thank you very much, Doctor. Do I have any questions from staff?

MR. BRANNEN: Yes. Can you -- I mean, you addressed some of the issues with mixed incentives or mixed payers, and gave some good examples. Can you talk about anything that would represent a tipping point? I mean, is it as simple as having most of your patients enrolled under a particular model? Is it some other sort of motivating factor? And, how far away from that tipping point will you really change the way you're structured and practicing care?

DR. BUTTERLY: This may be a somewhat naive answer, and I apologize if it is. But we've already met -- reached that. Our providers are essentially blinded to who the insurer is. I mean, I'm going to know, if somebody is over 65 years of age, they're Medicare. If they're under 65, I don't know who their insurer is. I don't see it when I see the patient, and I don't practice accordingly. I can't. I couldn't possibly do that.

The one way that really hurts is on formulary. And, am I prescribing a medication that is on that particular patient's formulary? That hurts the

patient and it hurts us, because I may not being doing that, but it's very hard for me to know it. The electronic records that we have, and we have Epic now, and it's a very popular one and a very big one, but that's not immediately put in front of my face. "Here" -- if I prescribe a statin, "here's the statin that this patient should be taking."

So, we have work to do. And, we need the time to transition. And, we need the opportunity to share in that cost savings, so we can take those dollars and put it back into our systems to see to it that we eventually can get to a global budget.

Did that answer your question?

MR. BRANNEN: Well, I guess going back to your canoe example, where you set one foot in each canoe, are you suggesting that you've already made the leap to single canoes, and you've abandoned the other one? Or are you still standing there with two feet, one in each canoe?

DR. BUTTERLY: Yes. We're still with two feet, just like everybody else is. But what -- how our providers are practicing on the one hand, and how our operations are being run are somewhat different. So, as a provider, I'm not looking -- you know, I'm on a salary, as

all of our providers are. I'm not saying, "well, I'm incented one way or another to do a procedure or order an imaging test." I'm there for the patient. And, that really has always been true.

On the other hand, our administrators, our operations people have to pay attention to our budgets. So, for example, we are either going to do what we can to see to it that we've got patients who want to come, that we're accepting referrals, that we're not turning people away. And, we have a little difficulty with access from that perspective. But, on the other hand, we have to control our costs. And, which we, unfortunately, a year ago had to do with voluntary early retirement and a small reduction in force. We have to pay attention to our budget. We have a fiduciary responsibility to our --

(Court reporter interruption.)

DR. BUTTERLY: We have a fiduciary responsibility to our trustees. We have to meet our budget, we have to perform. Did that answer your question?

MR. BRANNEN: Thanks.

CMSR. SEVIGNY: Did I have other questions from staff or consultants?

(No verbal response)

CMSR. SEVIGNY: Good. Well, again, thank you very much. And, I appreciate your coming and joining us this morning.

DR. BUTTERLY: Thank you.

CMSR. SEVIGNY: This brings us to the end of those that have signed up to provide testimony. Let me open it up and see if there's anyone else that would like to make any further comments?

(No verbal response)

CMSR. SEVIGNY: Okay. Seeing none, I want to thank those of you that took the time to be here and participate today. Also, thanks to Gorham Actuarial, Dartmouth Hitchcock, the health carriers, and Insurance Department staff. Again, thanks for participating. And, we hope to have the required annual report on our website in early November.

MR. BRANNEN: And, if there is written testimony, feel free to provide that now, or email us at the Department anytime after.

CMSR. SEVIGNY: Great. With that, I'll bring the hearing to a close. Thank you.

(Whereupon the hearing ended at 12:01 p.m.)