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) Third Annual Hearing**

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

APPEARANCES: **Reptg. the N.H. Insurance Department:**
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I N D E X

PAGE NO.

I N D E X (continued)

I N D E X

P R O C E E D I N G

CMSR. SEVIGNY: Good morning, everybody. My name is Roger Sevigny. I'm the Commissioner of Insurance for the State of New Hampshire. I'd like to welcome you to this public hearing concerning premium rates in the health insurance market. My opening remarks have been scripted for me, but, those of you who know me, know that I don't necessarily stick to a script very well. I tend to go, as they say, "off script". So, if you see my staff throwing things at me or whatever, it's because I've gone off script. Forgive me.

The Department is required to 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. Also, it requires that I prepare an annual report, which identifies and quantifies health care spending trends and the underlying factors that contributed to increases in health insurance premiums.

Before I continue with the script, let me just give you my own personal editorial comment. I think this hearing is extremely timely. All of us continue to hear about the costs and the rising premiums,

we've heard that for years now. And, not only the rising premiums, but, if you've heard me speak any time in the last ten years, you've heard me talk about the cost of care. And that, if we don't address the cost of care, then we're not going to do anything to bend the cost curve. You're going to hear testimony this morning about what goes into the makeup of premiums, what contributes to costs. One of the questions I'm going to ask any or all of the carriers to address, and I'm not sure -- I don't know if it's in their own works or not, is the question having to do with medical loss ratio, and how that -- under ObamaCare, and how that impacts what goes on within the development of health insurance premiums, and what happens if the medical loss ratio is not met, and what that does. I think you'll find it enlightening. And, again, as I said, I think it's very timely for us to be looking more deeply into what goes into the development of health insurance premiums.

Assisting the Department this morning with the task are people from Gorman Actuarial: Bela Gorman, if you could identify who you are; Jon Camire; and Jenn Smagula.

Department staff: I'm going to start with the person that helped us organize this, Deb O.

She's in the back of the room down there. She's the person who helps organize all things legislative and of that nature. Thank you so much, Deb, for helping us. Other Staff participating are Tyler Brannen, who really has the -- who is our Health Policy Analyst responsible for this particular hearing, the content of the hearing, as well as the development of the report that will come out of this hearing. Jennifer Patterson, who's our Life, Accident, and Health Legal Counsel. Those of you that have been to hearings or anything having to do with health recently have seen Jenny around, and have probably heard her speak in a number of forums. And, David Sky, our Life and Accident -- our Life, Accident, and Health Actuary.

Copies of the agenda and the participants are available at the entrance to the room. We're going to begin with a presentation of the Department's report, New Hampshire's Health Insurance Market and Provider Payment System: An Analysis of Shareholder -- "Shareholder" -- "Stakeholder Views, that's going to be done by the University of Massachusetts' School of Medicine and Freedman Healthcare.

This is going be followed by statements from New Hampshire's major health carriers, and questions. We have Anthem, Harvard Pilgrim, Cigna, and MVP with us

today. The health carrier participants are Lisa Guertin from Anthem; Tu Nguyen from Harvard Pilgrim; Peter Lopatka from MVP; and William Swacker from Cigna.

We're then going to hear from non-carrier participants, including members of the New Hampshire House. There's a -- and I see them sitting up front with us right now. There is a sign-up sheet. And, if you would like to present testimony or make comments or to ask questions, I'd appreciate your signing up on that sheet.

With that, I would request the presenters begin. And, first, let me remind you of a couple of things. Requests from our court reporter here: Speak into the microphone; any prepared remarks that anyone has, please provide them to him; speak one at a time; remember that there's someone recording the meeting; and try not to speak too fast.

We are also, I'm not sure what you'd call it, but *GoToMeeting* is operational, and that we've got, I believe, at least 17 people so far that have signed up to watch and listen to this hearing using the *GoToMeeting* facility. They will be able to participate at the end as well, if they so choose.

With that, I'd like the presenters to

begin. The first presenters are going to be Michael Grenier, from the University of Mass. Medical School, and Missy Garrity, from Freedman Health. If you could come up and introduce yourselves and present please.

MS. GARRITY: Good morning, Commissioner. Can everyone hear me?

FROM THE FLOOR: Yes.

MS. GARRITY: Oh, I'm going to turn my back a little. So, thank you for having us here today. And, as the Commissioner said, we're here to present to you a brief summary of a report that was conducted this past spring and summer, that was really intended to get a good handle on the stakeholder' views as it relates to the health insurance market, and, in particular, on the area of costs. I will be presenting with Michael Grenier, from the University of Massachusetts Medical School Center for Health Law & Economics, which we fondly call "chilly" **[**CHLE**]**. And, so, Martha, are you driving this one? Yes.

So, the goal of the project, as I said, is to get a better understanding of the New Hampshire insurance market. And, there are a number of factors influencing the market. What we really wanted to try to understand is those factors that are driving costs.

I think there are copies of the

presentation in the back. I see you all twisted around. You might be more comfortable if you have one in front of you.

So, the questions that we asked were in areas that were ones that we thought might particularly have an influence over costs, including the contracting environment, payment innovation, contracting and payment system reforms, delivery system reforms. And, then, we wanted to know what stakeholders had, in terms of recommendations for the Department and for the state, in terms of changes. So, this presentation I'll be talking about interview process.

Excuse me. There was also a data analytic component to the project that allowed us to look at the data to see how it supported the findings of what we were hearing from stakeholders. And, I think you'll see the results are interesting.

The complete study is posted on the Division website. And, I encourage you to take a look at it, because, of course, there is much more in the full report than we'll be able to cover here.

The next slide please. Martha? Oh, good. Thank you. So, the interview process: We talked with -- we conducted 26 interviews with stakeholders from

different areas, purchasers and consumers, carriers and providers. They received questions before the interview, and a briefing paper that set the tone for what we would be talking with them about. And, as I said, these were the areas of focus for the questions.

Before I get into "who said what about what", I think that what we found that's really important is that there are a lot of competing tensions, as you might imagine, in the market. And, what that means is that, even though everyone has the same outcome in mind, which is good value in health care, high quality, affordable prices. There's a range of solutions that people are thinking about and trying to implement that really run a great continuum.

So, for example, if you think about "how much regulation there should be in health care?" There are those that think "free market". Let's let what happens happen, and it will drive, like in other industries, to the right price points; others say "no", that there should be a fair amount of regulations.

Another area where there's a continuum of opinions is in the area of how care should be delivered. And, those that think "let the consumer choose at the right price point, give them site-of-service

options, and they will make those good decisions." Others say, "you know, we really think that coordination of care is the important thing. We want to keep our patients whole". Excuse me. "And, by offering them these site-of-service incentives, you're causing fragmentation in the system."

So, just keeping that in mind as you listen to the "who said what about what", it's really important to remember that, you know, everybody is really looking for a solution, the same solution, but in different ways.

So, next slide, we're going to start to talk a little bit about costs. So, in general, across all groups, there's a consensus that premium and out-of-pocket costs are too high. And, Michael will talk a little bit more detail about what the data show, but that we definitely are hearing that the premium costs is second highest in the nation, the deductibles are among the highest in the nation, and that some point to the geographic rating area, a single geographic rating area having something to do with the south subsidizing the northern New Hampshire.

From carriers, there was a strong emphasis on the consolidation of providers and how that is

driving costs. So, different examples: That physicians may be billing, but, because of their consolidation with the hospital, their -- those costs would be higher. And, that other -- another carrier noted that administrative costs are not scrutinized for providers, as they are for the carriers.

From the provider side, there was a lot of discussion about underfunding of Medicaid and how that leads to cost-shifting. Both -- all different types of providers express concern about cost-sharing, and how this would lead to patients not receiving care, because of their out-of-pocket costs.

And, then, from employers and purchasers, I think the main concern is about sustainability. And, employers talked about choosing to go to self-insured products, so that they have more flexibility. They talked about putting wellness programs in place, because they believe, ultimately, the healthy -- the healthy employee is the one who has less costs. And, I think people are thinking and looking ahead to the future, and being concerned about, in the long term, being able to afford to provide health care to their employees, and looking at the decisions that they need to make about offering health care as a benefit in the future,

particularly with the Exchange on the horizon.

So, then, competition: "What competition?", they say. So, for -- in the area of insurers, carriers feel that they're competitive with one another, that they compete on market son on service and costs. They say that purchasers are very price-sensitive, and small changes in the premium will have them make a move. They don't have the loyalty that maybe was there in the past or in other markets.

Providers don't think that the insurance market is competitive. They think that Anthem is the dominant force. They see it as a market-mover, and introducing new products that other carriers need to follow.

In terms of provider competition, I think that stakeholders generally agree that there's not a lot of competition, except in the south, Manchester, Nashua. I think that also, because of the geography of the state, there's a lot of agreement that it doesn't necessarily lend itself to a competitive market, in terms of providers. That they're mono-geographic markets. And, consolidation was also cited as a key challenge. Because of the alignment of physicians with hospitals, there's not going to be the same amount of competition among

providers.

Okay. Plan design: So, plan design, I mean, there were a few different strategies that were discussed. One was tiering, and this didn't seem to be one that was really strong -- there was a lot of positive feedback about that. It's difficult with a geographic distribution, it's difficult because of loyalty in some markets. Patients want to stay with their provider. And, there was a lot of discussion about the site-of-service plans and the impact that that has on providers. And, also, as I said before, the fragmentation of care is another issue.

Specifically, providers expressed concern about the increased use of self-insured plans, which we see there's a large number of employers moving to self-insured, and the impact that that has on the fully-insured pool.

And, from purchasers, they agree that the site-of-service model is one that is effective in reducing costs. They also think, as I said earlier, that the move to self-funded gives them more flexibility, and the importance of wellness programs. Both employers that we spoke with had put wellness programs in place and saw that as a way to help support their employees in achieving

good health.

So, delivery and payment reform: There's, I think, a common, across all groups, people think that coordination of care and thinking about population health is the right thing. I think, beyond that, we start to see people going in different directions, in terms of solutions. There was a fair amount of discussion about the Certificate of Need process and how that could be improved. And, you know, the idea that, you know, supply drives demand, and some concern about continuing to build and making new capacity available. There is also an overall concern about the availability of mental health and substance abuse services. And, more than one stakeholder referred to this as an area -- a "crisis" area for the state.

From providers, there was a lot of discussion about many of the initiatives that are underway; Shared Savings, Accountable Care Organizations, the G5. These were all things that were discussed as positive ways of changing the delivery system. And, providers said that they're interested in assuming more risk, yet, on the other hand, there was one provider who was concerned about their ability to actually successfully have this type of a model, because of the technology

infrastructure that's needed to support this. And, also, on that theme, providers said that they needed more funding for technology, to be able to support population and performance data analysis to have better population management, health management.

So, with that, I'll turn it over to Michael to talk a little bit about the findings from the data analytics.

MR. GRENIER: Good morning. As Missy mentioned, while going through the interviews, we heard a lot of comment from individuals regarding the high cost of health care in New Hampshire. So, when we look at the data, we do find, in fact, that the costs in New Hampshire are the second highest costs in the nation, at least in 2011. It was second only to Massachusetts. And, notably, though, New Hampshire family premiums are lower as a percent of median family income than nationally. But that is simply a factor of the higher rates of income that we have in New Hampshire.

Next slide please. In terms of cost-sharing, New Hampshire's average deductible for a family plan is about 25 percent higher than the Massachusetts deductible of about $2,100. And, New Hampshire's deductibles are about the third highest in the

nation, about 30 percent higher than the national average. And, we see the same thing on the single premium side as well. So, New Hampshire's average deductible -- sorry, single deductible side as well. So, New Hampshire's average deductible for a single plan is about 24 percent higher than the national average.

And, also, the supplemental report from 2011 that insurers submit to the NHID shows that high deductible health plans have been increasing their market share in New Hampshire. So, from 2010, it was about 11 percent of members, and, in 2011, it had grown to about 18 percent of members. So, the perception that we heard throughout the interviews that premiums and cost-sharing are rising and are continuing to be a challenge is, in fact, borne out by the data.

Next slide please. We took a look at the competition using a standard metric that is used often by the Department of Justice, it's the Herfindahl-Hirschman Index, which completes the calculation to figure out how competitive markets are. So, the HHI score that's under 1,500 indicates a very competitive market, anything between 1,500 and 2,500 shows moderate concentrations, and anything greater than 2,500 is highly concentrated. So, in short, the higher

the score the less competition you would see in a given market.

So, we looked at carriers and hospitals. For carriers, we define the market share as a percent of total members. Whereas, for hospitals, we define the market share as percent of total payments.

Next slide please. In terms of carriers, we found low competition amongst all of the group types. So, for the Large Group market, it showed about a moderate concentration, which indicates some competition, but not a significant amount. The Small Group and non-group markets were highly concentrated, indicating very little competition in those markets. But for the small and non-group, that's not unusual for a state to have this. I've cited a statistic here from the Kaiser Family Foundation that found that, in over 45 states in 2010, the small and non-groups had scores that were greater than 2,500. So, this is actually typical across the country.

Next slide please. We also tried to look at competition among the hospitals. And, this is a bit more challenging, because, in order to look at competition among hospitals, we had to define given regions. So, obviously, there's some flexibility in how

we defined the regions. So, we -- anything in the northern country was -- none of those were competitive markets, because there's a high concentration of critical access hospitals or sole community providers. So, we focused on three areas of the state. What we call the "Mid-State 93", which is highlighted here in the green; the "Coastal Region", which is highlighted off to the right in the red; and, then, the blue is "Nashua-Manchester Region".

So, Mid-State I93 was highly concentrated, whereas Coastal and Nashua-Manchester were moderately concentrated. But, again, it did not indicate very strong levels of competition.

Some key caveats to this analysis, though, we didn't include border hospitals, which would certainly change these numbers, because hospitals -- patients, obviously, cross borders between Massachusetts and Vermont. It does not include specialty hospitals, because they have a unique set of patients. We also did try to see what would happen if we moved Concord into the Nashua-Manchester Region, but it actually didn't really change the results terribly.

Next slide please. We completed a -- we sent a survey to five of the largest carriers in New

Hampshire's -- in New Hampshire, and obtained three responses. And, what we asked the carriers to do is to provide us information on how they're currently paying their providers and how they're designing their networks, in terms of using tiering or limited networks.

In terms of payment arrangements, we did hear throughout the stakeholder process that they had -- that many people had an interest in exploring alternative payment models. But the data, at least in 2011, which is a few years ago now, did not indicate a wide use of alternative payment models. So, only about 12 percent of payments were reported using global payments, downside risk. Those were paid to Accountable Care Organizations. Less than one percent, almost zero, were paid using bundled payment arrangements, for acute and chronic conditions. An example of a bundled payment arrangement would be like knee replacements, where it's a single payment that would cover the physician care, the hospital surgery, and then some post-acute care.

So, of the fee schedule and charge-based payments, about 20 percent were using pay-for-reporting or pay-for-performance incentives. So, in general, in 2011 at least, the predominant method for payment was fee and charge-based payments. And, that includes things like

using DRGs or per diem payments and other outpatient fee schedules.

In terms of tiering, we also asked the carriers to report to us how they're designing their plans. So, tiering is when the carrier has -- carrier assigned providers to tiers based on quality and cost metrics. A "limited network" is when a carrier is restricting patients to a very specific list of providers. So, for this -- purposes of this survey, we asked specifically about doctors and hospitals. So, the numbers here are lower than what I've seen reported elsewhere to the Department.

But, in general, what we found is that there is a very limited use of tiered networks. And, most of the carriers were -- most of the patients or most of the members were in "unlimited", not tiered networks, the very broad bar at the bottom.

So, finally, to wrap up, just to focus on what we heard throughout this entire process from the stakeholders regarding recommendations, the first was that the stakeholders felt that the Department could help create a shared long-term vision on the health of the New Hampshire population and align policies and regulations to support that vision. They felt that the Department could

continue to support transparency and develop tools to make information and data more accessible. And, generally, the stakeholders felt strongly that the Department had been taking a lot of initiative in that area.

Also, to -- the NHID could play a convening role in the development of new payment models, such as developing guidelines for new models and supporting pilots. We also heard clearly that NHID and other state agencies should address provider payments by encouraging more use of alternative payment methods and then addressing the public payer shortfalls.

Universally, we felt -- we heard that carriers and providers supported an increase in investment in primary care, and also a reform of the Certificate of Need process. Although, on that last point, there were a number of differing opinions about how best to change the Certificate of Need process.

And, that concludes our presentation. Are there any questions?

CMSR. SEVIGNY: Good. Thank you very much. We ask members of the Department if you've got questions that you'd like to ask our panel?

MR. BRANNEN: Yes, I do have a question. First, I have a comment. We asked the folks who came to

present this to do almost an impossible task, really, to summarize so much information. And, it's available in the report on our website. So, if you go to the Insurance Department website, you go to the left side, there's a "Report" tab, and you can find it, the report that all of these data came from in there. And, I highly encourage you, if haven't done so already, to just take a look at that report. There's a lot of good information.

My first question is, is you've done similar work in other areas. Is there anything that stood out to you as particularly unique about your findings in New Hampshire?

MR. GRENIER: I think that, and Missy could probably speak to this a bit more, but there is a significant amount of innovation currently going on in New Hampshire. The two employers Missy had spoken with were very focused on wellness initiatives and providing access to, for their employees, to primary care. So, there is a fair amount of, from the ground up, movement towards trying to embrace changes in the health insurance market. Do you want to add to that?

MS. GARRITY: Yes. I just definitely agree. And, I also think, on the provider side, we see a number of initiatives that are underway that are these

grassroots types of initiatives. I mentioned the G5. There's the North Country Health Center Group that came together to take advantage of a shared-savings model. There's the work that's being done at Dartmouth. There is the Citizens' Initiative for Health. I mean, there's just a number of these organizations that are working towards finding new models and new opportunities. And, I think that that's really a spirit that -- with a consistent theme that we heard.

CMSR. SEVIGNY: Questions? Jenn.

MR. BRANNEN: I have another question.

MS. PATTERSON: Okay. Well, go ahead. I'm still trying to figure out how to say my question.

MR. BRANNEN: Okay. You did an analysis, basically, of hospital competition in the state. And, I don't think your findings are that surprising. I think most people consider that there's relatively low competition among hospitals in New Hampshire. Something that is new in New Hampshire now that we're dealing with is a narrow network situation among our major carriers, and the Insurance Department is responsible for network adequacy rules. So, I wonder if you can kind of speak to the fact that there sounds like there's relatively low competition, but, at the same time, now we've got a

network that's far more limited. And, really, to the extent that we have network adequacy rules, are they adequate among themselves or should the state be doing more, I guess, to make sure that there is an adequate network? Now, if you can just speak to, I guess, the different concepts between what is necessary for a hospital network versus what would be a competitive environment?

MR. GRENIER: Uh-huh. I think the challenge would be to, as you go forward with that, to focus on what the data shows, in terms of making sure there is continued access for that. As we indicated, that there are certain pockets that are a bit more competitive than other areas of the state. So, the further north you get, I think the challenge of network adequacy will become more salient and more important to focus on and to monitor. So, that's it.

MR. BRANNEN: As a follow-up, I mean, do you find, in other environments you've looked at, whether it be Massachusetts or otherwise, that you find similar low levels of competition, but also narrow networks developing?

MR. GRENIER: Yes, to some extent. In eastern Massachusetts, which is where we do most of our

work, I mean, we don't have the same challenge of low competition. I mean, there's a significant amount of competition. However, in the eastern -- in the western part of Massachusetts, it is certainly a challenge in certain areas. So, I think that that is a unique challenge for New Hampshire, is the high number of community -- of critical access hospitals in the state and trying to ensure that network adequacy. So, I think that is the unique challenge for New Hampshire.

MS. PATTERSON: Missy started by talking about kind of the continuum of views and, really, the diverse nature of the stakeholders that you interviewed. And, in looking at the stakeholder recommendations at the end, I'm just wondering if you could talk a little bit more about that continuum, and the relationship between that continuum and the recommendations. So, for instance, were there any areas in the recommendations where there appeared to be more of a consensus across the continuum or as kind of next steps that really might have more consensus behind them?

MS. GARRITY: Well, first, I think the recommendations that we pulled forward from the process were ones that we heard more consistently than a random offshoot. So, for example, reform of the Certificate of

Need process. And, as Michael said, you know, there would be -- there may be a common theme that this is an area to focus, but not necessarily a clear strategy or a single strategy on how to resolve it. I do think that the notion of there being a clear vision for the state, in terms of about the health of the population, and aligning policies and regulations accordingly, was another one that you could hear more consistently. As I said, you know, the underlying theme was that "we all want the same thing." We all want good value for the population and good health for the population. I don't know if that helps?

MS. PATTERSON: Yes. Thank you.

CMSR. SEVIGNY: Any other questions from the Department? David, do you have any?

MR. SKY: No. I'm all set. Thanks.

CMSR. SEVIGNY: Good. Well, thank you very much for coming before us this morning.

MR. GRENIER: Thank you, Commissioner.

CMSR. SEVIGNY: And, thank you for your very condensed Reader's Digest version of your report. And, as Tyler said, you can see the entire report on our website. And, anyone who's interested in what they have had to say and want to see more information, please take a look at the website.

MR. GRENIER: Thank you.

MS. GARRITY: Thank you.

CMSR. SEVIGNY: Next, we're going to hear from the Insurance Carrier Panel. And, we're going to start with Peter Lopatka, from MVP Health Care. Peter.

MR. LOPATKA: Okay. Thank you for the opportunity to testify this morning. My name is Pete Lopatka. I'm the Vice President and Chief Actuary at MVP Health Care. Founded in 1983, MVP Health Care is a community-focused, not-for-profit health insurer serving members in New York, Vermont and New Hampshire. Through its operating subsidiaries, MVP provides fully-insured and self-funded health plans to 733,000 members, including 7,000 New Hampshire residents.

MVP has supplied regulators with specific data and information requested on health care costs and premium rates in New Hampshire. In my prepared remarks, I will provide this information in the same order as the Department posed its questions. After my remarks, I will be happy to answer questions posed by the Insurance Department with respect to this information.

So, Question 1, which was regarding assumptions in our premiums today. So, in terms of unit cost, utilization, and mix, for 2012 and 2013 premium

development. So, services performed in inpatient settings were the largest driver of our assumed unit cost increases used to develop 2012 and 2013 premium rates. MVP projected an increase in physician utilization rates to have the largest impact on 2012 and 2013 rates. Intensity and mix of services were not factored into MVP's pricing assumptions for 2012 and 2013 rates.

The 2012 premium rate trends subdivided by major service category were as follows: For inpatient facility: We assumed 6.3 percent unit cost increase, 2 percent utilization; outpatient facility, 6.2 percent unit cost, 2 percent utilization; physician, 4.7 percent unit cost, 3.5 percent utilization; pharmacy, 1.9 percent unit cost, 1 percent utilization.

On Question 2, regarding the primary drivers of unit cost, utilization, and mix, in the actual experience from 2011 to 2012 and early 2013. In 2012, inpatient fee-for-service claims had the largest impact on our -- on our cost. The largest driver of utilization trend in 2012 was physician claims. The risk of the MVP's population improved by 3.4 percent, based on the average age and gender of members purchasing coverage in 2012, when compared to 2011.

Now, I'll read through the actual trends

that materialized for 2012: Inpatient actual, 21 percent unit cost, 1.1 percent utilization; outpatient facility, 10 percent unit cost, minus 0.6 percent utilization; physician, 6.2 percent unit cost, 2.2 percent utilization; and pharmacy, 3.0 percent unit cost, minus 3.5 percent utilization.

So, the third question that was posed was regarding strategies and innovations implemented since 2011 that impact premium or trend. And, MVP is currently using a number of medical management techniques, including: Due to a steady upward trend of inpatient admissions per 1,000 over the past several years, we have sought to prevent unnecessary inpatient stays by using tools such as site-of-service reviews and validation. We have been working to shift utilization of prescription drugs from brand to generic, where medically appropriate, through educational communications to providers and members. And, we have made strategic changes to our drug list.

We have been working with a vendor to implement comprehensive evidence-based radiology criteria to manage high-tech radiology services. We have sought to reduce unnecessary emergency room usage by educating members on medically safe alternatives, such as Urgent

Care centers. We proactively review clinical edits applied to medical claim processing to ensure that correct coding rules are followed. In addition to the medical cost initiatives described above, MVP has initiated several workforce restructuring initiatives in 2012 in an attempt to streamline and reduce administrative costs.

And, the fourth and final question posed was regarding the impact of the Affordable Care Act on MVP's actual experience through early 2013, and then the expected impact through 2014. MVP has implemented requirements of the Affordable Care Act, but does not have a large enough set of data to analyze their impact through early 2013.

Move to the expectation. The women's wellness mandate and Small Group essential health benefit requirements are expected to have the largest impact on claims through 2014. Under the women's wellness mandate, contraceptives are covered in full, and benefits have been expanded to cover services such as sterilization and breast pumps in full. MVP estimates the essential health benefit requirements to increase Small Group claims by approximately 3 percent.

Thank you for your time. And, welcome any of your questions.

CMSR. SEVIGNY: Good. Thank you very much, Pete. We're going to hold our questions for the Provider Panel until each of you has had a chance to present.

Having said that, we're going to move to Tu Nguyen, from Harvard Pilgrim, if you would provide us with your comments please.

MR. NGUYEN: Do you hear me now? Thank you, Commissioner. Good morning. My name is Tu Nguyen. I am the Vice President of Actuarials at Harvard Pilgrim. With me, I have Brian Lewis, the Senior Actuarial Manager. And, also joining me is Teresa Gallinaro. She is our Legislative Consultant.

Before I go into the questions, I would like to touch on about the background of Harvard Pilgrim, and also touch on at a high level of cost of care issues that we have in New Hampshire.

Harvard Pilgrim is a nonprofit organization. We operate in Massachusetts, New Hampshire, and Maine. We cover roughly, I would say, 1.2 million lives, about 135 [135,000?] lives in New Hampshire. When it come to health care, well, we are the New England Patriots.

We recently ranked Number One again for

tenth straight year in the country by the National Committee for Quality Assurance. The New Hampshire plan is first in New Hampshire, and ninth in the nation. The ranking is based on clinical measurements, customer assessments, and accreditation standards. We are fully committed to the private market, as well as the public programs. We show our commitment by working with the states providing coverage to thousands of New Hampshire children through the Healthy Kids programs. We also support the Medicaid expansion to increase access to low-income individuals. We partner with WellSense. One of the managed care organizations contacted with the states to provide Medicaid programs. We work with WellSense on network development and provide the relation to promote good quality care in an effective cost manner.

Earlier you heard the presentations about the issues that we have in New Hampshire. And, point out the facts that -- that high cost of care in New Hampshire continues to be a serious problem.

In addition, we have the uncertainties about the possible effects of Affordable Healthcare, particularly small business in New Hampshire. The premium rate increase have been problems. There's a lot of cost-shifting from the employer to the employees. As

mentioned earlier, that the premiums for 2011 are roughly 17,000, and it is the second highest in the nation after Massachusetts. The average premium deductible is also high, 25 percent higher than Massachusetts. And, it's double the deductible for the lowest states.

Even though medical cost increases have moderated since the recession, we still seen it's increasing. ACA also adds some additional mandated benefits. It is understandable why small business are feeling vulnerable.

Now, we get into specific questions. For the first two questions, I would like to turn it over to Brian Lewis. He's going to go over that, that two questions.

MR. LEWIS: My name is Brian Lewis. I'm senior manager of our corporate actuarial area. What were the primary drivers -- Question Number 1, "What were the primary drivers of unit cost, utilization and mix assumptions used in the 2012 and 2013 development?" In developing our 2012 and '13 premiums, we continued to assume that the largest driver of trend increases would be the provider unit cost increases. For 2012, we expected unit cost increases to be in the mid-single digits. In terms of utilization and mix, we expected that lower unit

-- that lower intensity services would move from the inpatient to outpatient facilities, something that we've observed for a number of years. And, we continue to expect, with technology and practice patterns, that that will continue for the near future. We expected -- as a result, utilization would be flat or slightly positive for inpatient services, or higher for inpatient services, and a little bit higher than that for outpatient services, probably in the zero to 5 percent range. We would expect service mix to be slightly lower, reflecting the migration from inpatient to care in outpatient settings.

For 2013, unit cost increases were expected to be lower than in previous years, driven by more favorable provider contract negotiations that have led to lower increases. As well as we renegotiated our contract with our pharmacy vendor, which achieved some sizable discounts for 2013. We also expect utilization to follow the same pattern as 2012, remaining slightly flatter or slightly higher for inpatient services, and a little bit higher yet for outpatient.

For Question Number 2, "What were the primary drivers of unit cost, utilization, and mix in actual experience trends from 2011 to 2012 and '13?" For 2012, we saw better unit cost increases than we expected,

probably something along the lines of half to a percent through negotiations. We continued to observe moderation of utilization in inpatient facilities and higher utilization in outpatient surgeries as expected. We also observed utilization for radiological and the lab procedures was lower than expected. For 2013, results have emerged near to what we expected. Thank you.

MR. NGUYEN: So, to answer the next two questions, innovations: There's two type of innovations. One of them is products. Since 2011, we do have three new products coming out. We have the Best Buy-LP. The "LP" represents low-cost providers. We tier certain providers outside of hospitals. The low-cost provider are chosen based on cost and quality. We have the ambulatory surgery centers, we also have independent labs for included low-cost providers. For those who use the providers will pay lower cost share or even no cost -- no cost shares at all. By doing that, we're encouraging the members to use low-cost providers, and we can influence trends in positive directions.

The second product innovations that we have, actually, it is a modification of the Best Buy-LP that we have. This is the "Hospital Prefer". It has all of the features of the LP design. However, we also, on

top of that, we tier the hospital.

So, Tier 1 of the Hospital Prefer is basically based on costs and also quality. So, any members going to a Tier 1 would pay lower deductibles. The next higher deductible would be Tier 2. And, then, the last one would be Tier 2 -- Tier 3, sorry.

The third product innovations that we have is "Elevate Health". It is an innovation product based on coordination of care, reliable quality, with better experience, while controlling costs. We have five hospitals, five New Hampshire hospitals in Elevate Health. We also have one Boston pediatric hospital for complex, rare, pediatric cases. We have 400 primary physicians in Elevate Health. We also have on the order of like 2,600 specialists.

Elevate Health would bring together health plan and provider clinical data to identify at-risk populations, and trying to avoid duplication efforts between Harvard Pilgrim and providers around care coordination and care management. And, by doing that, we would expect the following outcomes: It would lower costs and better member quality of life to reduce re-admissions; fewer emergency rooms; fewer complications from chronic diseases; reduce the numbers of duplicative and suboptimal

services; improve member experience and satisfaction; higher level of member engagement; and also improved coordination within the health care delivery system.

The second type of innovation is "Provider Payment Models". I'm just going to mention the program. I think we do provide the details in the written testimony. We have the "Primary Care Center of Excellence"; we also have the "Specialist Medical Home"; "Global Case Rates"; "Complex or Progressive Condition Management".

For the last questions about the impact of Affordable Care Act, I know that the Commissioner asked earlier about the minimum requirement on MLR. Harvard Pilgrim is a nonprofit organization. So, we normally target higher MLR. So, the MLR requirement does not have any impacts on the premiums developments in our network.

In terms of all the impacts, the Affordable Care Act does have impacts on the premiums, I would say, in the mid-single digits. We have the reinsurance surcharge, which is around like 5 percent. We also have the new tax, which is between like 2 and 3. And, then, there are some additional mandates, like the pediatrics, dental, the vision, and all that. So, add it up, I would say roughly mid-single digits.

That would conclude my testimony.

CMSR. SEVIGNY: Good. Thank you very much, Tu. Continuing on, let me move to Patrick Gillespie. That is not William Swacker up there, he's sitting over there. Anyway, Pat if you would provide us with your comments.

MR. GILLISPIE: Sure. Thank you, Commissioner. Thank you very much. And, I'm Pat Gillespie, Director of State Government Affairs, here for Cigna. I serve a 9-state region, which includes New Hampshire, as well as other states here in the Northeast and the Mid-Atlantic Region. On behalf of Don Curry, who's the General Manager here in New England and the business lead for this market, and our 400 employees in our Hooksett facility, and 120,000 customers, both Large Group insured and self-funded customers, thank you for having us here and giving us the opportunity to present.

I've been with the Company for two years, prior to that serve 18 years in state government. And, at Cigna, I can say that, you know, we firmly believe in our mission statement, which is to prove -- improve the health, wellbeing, and financial security of our customers. We are a global health care company. We operate in all 50 states and in 32 foreign countries.

And, again, we believe that we want to recognize the individual uniqueness of each person and try and tailor products to them to best meet their individual needs.

With me today is Trey Swacker. Trey is the Pricing Lead for Cigna, and has been with the Company for about 11 years now. And, he's going to answer the four trend questions and questions related to this. Trey.

MR. SWACKER: Okay. Thank you. Can you hear me? All right. So, to the specific questions. So, the primary drivers of unit cost, utilization and mix trends, what were the assumptions used in our 2012 and 2013 pricing? Our unit cost outlook, and again, it's based on models and expected fee schedule increases with health care providers, physicians, and hospitals, it's been in the mid-single digits, the 4 to 5 percent range in aggregate, for both 2012 and 2014.

Our utilization take and mix of service take, we do look beyond just the New Hampshire residents and members when looking at historical utilization trends and patterns in our book of business. And, utilization trend has been low, in the zero to one percent range nationally, for a number of years. We had set our outlook initially for 2012 and 2013 modestly above the historic low utilization experience, expecting, you know, as the

economy recovered, you could see some continued increase in utilization of services.

However, I would say we, specific to the 2013 premium development, took that down a little bit further. And, as we go into our 2014 outlook, which the rate filing is underway right now, the utilization outlook is really in line with the recent experience period. So, no longer projecting a significant increase over the recent trends.

Moving onto Number 2, with the observed trend, "what were the primary drivers of observed unit cost, utilization, and mix in experienced trends?" And, really, I'll talk specifically to utilization trend, the unit cost trends were generally in line with the expectations as we weren't allowed fee schedule increases. Utilization trends, as I mentioned, they were lower than expected, moving from 2011 to 2012, particularly with inpatient and outpatient facility services. We had expected zero to modestly negative inpatient trends, and they came in even better than that. Within professional services, there was a positive utilization trend, low single digits. But we saw the highest trends in services like routine office visits, immunizations, professional surgeries, and administered drugs. So, we would consider

that good and evidence that our members are going and receiving primary care and preventive type care, and then lower utilization in other categories within the professional spends.

Specific to pharmacy, again, I would say the utilization, if you look at our observed trend that we reported in New Hampshire, over 2011 to 2012, and into early 2013, it has moved around a bit, but we've had a change in mix. So, for self-insured customers that can purchase pharmacy coverage with us or carve it out, we had an increase in penetration or density of that product, and, so, it drove up observed utilization trend, moving from 2012 to -- 2011 to 2012, pardon me, and then has leveled off into 2013.

Moving onto the third question, "What strategies or innovations have been implemented since 2011?" The innovation that I would highlight is really our focus on pursuing collaborative accountable care relationships with providers and moving away from traditional contracting arrangements. So, we have collaborative accountable care relationships with Dartmouth-Hitchcock, that dates back to 2008. But, more recently, with their Granite Health Network, which is -- comprises five facility systems; Elliot,

Wentworth-Douglass, Concord Hospital, Southern New Hampshire Health System, and LRG Healthcare. And, combined, we have 30,000 aligned members, which means looking at past claim data, who's visited providers, who's associated with those provider groups, almost 30,000 aligned members. And, that's over 15 percent of our membership in this state.

And, in terms of the cost savings that we expect to achieve with these strategies and innovations, it's really I'd say it's more than just cost savings, it's improved outcomes and improved health of those numbers, which may or may not come at a lower cost, depending on what their historical trends or utilization patterns were. But, you know, in terms of the pricing outlook, we price a neutral outlook. So, there's no prospective increment or decrement to the rates for entering into the collaborative accountable care relationships. It's a sharing of data with providers, providing this information on gaps in care, pharmacy compliance, so that the health care provider can get outreach to the patient. To the extent that they do bend trend or, you know, there's lower -- even better health outcomes and lower trend, again, most of the membership that we cover, it's through self-funded arrangements with

employers. Or, even if fully-insured, we have a number of participating fully-insured arrangements, where, if there is lower trend, the clients and customers benefit directly, because they are funding their own or taking their own claim risks.

Moving on to Question 4, "describe the impact of the Affordable Care Act through early 2013 and expected through 2014." And, my comments here are specific to the Large Group market. We do not participate in the Small Group or individual market in New Hampshire. So, you know, within the Large Group market had modest impacts in 2013, again, for adding coverage for women's health and preventive services, you know, less than 1 percent. I think it added probably half to 1 percent in cost. And, again, depended on the level of coverage that employers offered previously.

As we move into 2014, so, there's, you know, a couple of changes coming in. One related to, again, mandated levels of benefit coverage. There's, for 2014 policy years and beyond, out-of-pocket cost-sharing may not exceed $6,350 for an individual, or double that for a family. And, there are certain clients that have deductibles that are at -- or, out-of-pocket maxes that are at that level or above. Or, if they're at that level,

the plan design may have co-payments or things that may not count towards the out-of-pocket max, if there's co-payments for specific services. So, it is driving some benefit changes for some clients that will have a varied level impact. Not many, I'd say most are below that level, in terms of the potential out-of-pocket liability that a member could incur.

And, then, also the taxes and fees of the Affordable Care Act, the three taxes that are in play for '14. There's a Comparative Effectiveness Research Fee, we've got that at $2.12 per member per year; a Reinsurance Assessment at $53 per member per year. And, then, if the clients are insured, there's a Health Insurance Industry Fee. We're estimating that at 2.2 percent of premium. Though, that would grow as you move into 2015, because that is a fee that ratcheting up for calendar year '14, '15, and '16.

CMSR. SEVIGNY: Good. Thank you very much. Next, we'll move on to Lisa Guertin from Anthem.

MS. GUERTIN: Thank you very much. And, good morning. My name is Lisa Guertin. I'm President of Anthem Blue Cross & Blue Shield in New Hampshire. Anthem is the state's largest and longest-serving health plan. And, we are very committed to the New Hampshire market.

As I believe you saw reflected in the information that was shared by the folks from UMass, we are the only insurer that is currently serving all segments of the commercial market. So, that's Large Group and Small Group, self-funded groups, seniors, and the individual market as well. And, as it turns out, our Exchange participation for 2014 is no exception. We are the only insurer who will be offering plans on the Exchange for 2014.

Like last year, the first two questions asked us to talk about what we assumed about unit cost, utilization, and mix when we set our rates, and then what actually happened. So, for simplicity, I will answer those two questions together.

Overall, when we set our premium for 2012 and the first half of 2013, we assumed that trends in the aggregate would go up slightly from long-term averages, primarily because we thought we would begin to see some utilization rebound. As you'll recall, we reported at this hearing last year, the economic downturn has clearly impacted and reduced utilization. People were getting fewer services. And, we thought that would begin to move up in this rating period, because, with trends, inevitably what goes down, does come back up.

Specifically, we thought we would see

that rebound somewhat in outpatient, professional, and pharmacy, because they were very clearly impacted for several years by the recession. For inpatient utilization, which is less sensitive to the economy, we expect the trend would be pretty much be at its long-term average. But, overall, we did think that trends based on utilization would increase.

In fact, for 2012 and the early part of 2013, trends came in lower again, with utilization still down across all types of services, except certain professional service categories. And, this did surprise us a bit, as it did many industry analysts.

To break that out for you and into categories, when we filed our rates, we, like the other carriers you've heard from, thought that trends based on contracted unit cost increases would improve slightly from long-term averages. So, they would be held a little more tightly than they had in the past. That did occur. And, one of the things that helped in the category of "outpatient services" was the success that we had renegotiating outpatient surgery hospital rates, as ambulatory surgical center use started to pressure hospitals to be more price-competitive. So, that had a positive unit cost impact.

We thought that professional or physician unit cost increases would remain consistent with their long-term average. And, they came in just slightly better than that.

Pharmacy as well, we thought unit costs there would remain at their long-term averages. We knew that brand-name drug inflation would continue, and the actual trend came in very close to our assumptions there.

Overall, our medical and pharmacy trends based on mix were assumed to improve. And, while this, in fact, occurred, it happened a little bit differently than we expected. Pharmacy mix was improved a little more than we expected, because we saw not only a positive impact from some big brand-name drugs going to generic, coming off brand, but we also saw more conversion to generic use by our customers than we expected. On the other hand, medical mix for us improved a little less than we expected, because we saw a drop in lower cost inpatient days, for things like substance abuse and skilled nursing, that was disproportionate to the drop in more expensive, acute care inpatient days.

We thought it might also be helpful just to give you, at a summary level, which kinds of care went up the most year over year and which kinds went up the

least. And, for simplicity here, I'm focusing on our group experience, not our individual experience, which is significantly smaller. Looking at the three types of trend, back to unit cost, mix, and utilization, like some of the other carriers, unit cost, or how much we pay for services, went up the most. And, within that category, drug costs did lead the way. In terms of type of service, the biggest category of cost growth was outpatient. And, specifically, outpatient mix contributed most to that increase. And, at the other end of the spectrum, the smallest increases, or, in some cases, even decreases, were on inpatient and outpatient utilization.

I'd like to take just a minute to talk about site-of-service, since it got a lot of attention in the report from the University of Massachusetts. We did see that the migration of lab and pathology services from "outpatient" to the "professional" category continues to produce a favorable result, for outpatient, and, in fact, for the whole entire health care spend in general. We do believe that this can be attributed to the site-of-service plan design, which, as you'll recall, incents members to get lab work done at lower-cost lab location through less out-of-pocket expense for them when they do.

Through site-of-service, mix is also

favorably impacted as a result of more members using ambulatory surgical centers for their surgery. And, unit cost sees a positive impact as well, because we've had success renegotiating outpatient surgery hospital rates as a result of that ASC utilization increase.

So, I think those things illustrate how this benefit design, although it certainly gets some negative attention in the Report, has really had a favorable impact on cost in multiple ways.

Question 3 asks us to comment on strategies or innovations that have been implemented that help control premium cost increase or trend. And, overall, we continue to focus on delivering a comprehensive set of high-value programs that help ensure medically necessary care is delivered at the right setting, without adding unnecessary administrative burden or expense. And, in aggregate, we do know that these programs are effective in helping to control the rate of increasing costs over time. So, that includes some of the mainstay programs, like hospital utilization review, and prior off programs. And, in those areas, we've added new programs, like the OrthoNet Program, for physical and occupational therapy, which are helping to manage costs for those spend categories. Quality programs, like

radiology management, health anticipated safety, as well as in control costs, neonatal intensive care management help ensure the appropriate level of care and smooth discharge planning for high-risk newborns. We call 100 percent of people when they are discharged from the hospital. And, preventing unnecessary re-admissions remains a very important focus area for us.

We have a program called "My Health Advantage", which actually improves treatment that patients receive by identifying and closing any gaps in their care using market meeting technology. And, then, we have a very broad set of programs under our 360 Degree Health Program that provides support wherever our members are on the health continuum, through complex care management, as well as wellness and other types of education.

So, those things are collectively extremely important. But I believe one of the most important initiatives that we have underway is in the area of payment innovation. And, we're really proud that, since 2011, we've made some extensive progress in this area. We now have 16 of our 26 in-state hospitals participating in our Quality Hospital Incentive Program; that's up two hospitals since I was here last year. Our

Anthem Quality Insights Program is in place with over two-thirds of primary care physicians in our network.

Our ACO arrangement with Dartmouth has been extended through 2014 and is producing very positive results. This is a true risk-sharing arrangement that covers approximately 20 percent of the providers in New Hampshire. And, we continue to have discussions with other large systems about putting ACO arrangements in place.

You heard in the UMass Report that one of the challenges that was identified by stakeholders is the difficulty that providers have, even if they want to get involved in risk arrangements, it can be very hard to have the infrastructure necessary to do that. And, that's where our new Patient-Centered Primary Care Program I believe is so important. As promised last year, this was rolled out in January '13 to primary care practices statewide. This provides those practices with the resources they need. So, that is the data, the tools, and the financial incentives to help those practices transform into true Patient-Centered Medical Homes. And, it rewards those providers whose efficiencies and outcomes meet both cost and quality levels. To date, nearly 40 percent of the PCPs in our network are participating in either an ACO

arrangement or this Patient-Centered Primary Care Program. And, we expect this program will not only improve quality outcomes and patient satisfaction, but we do forecast that it will save New Hampshire millions of dollars in health care spend between now and 2016.

The last question asked us to comment on the impact of the Affordable Care Act, on actual experience in 2013 and the expected impact in 2014. And, as we know, overall, the ACA does create some upward pressure on our required premiums, in the form of benefit enhancements, risk pool deterioration, as well as some new taxes and fees.

Depending on the market, the impact of the ACA, in 2013, is between 1 and 3 percent of premium. Beginning in 2014, the impact of guaranteed issue will be more apparent, as will additional taxes and fees that are associated with ACA and the Exchange marketplaces. The group market impact for 2014 we forecast will be between 3 and 5 percent. The individual market is closer to 50 percent, let's say 30, 40, or 50 percent impact, driven by the claims of the previously uninsured, and those in the high-risk pools coming into the pool that's used for rating the individual market.

In response to these impacts, we

continue to seek out lower-cost alternatives to achieve affordability, without sacrificing quality. And, I'll look forward to discussing some of those during the panel. Thank you.

CMSR. SEVIGNY: Good. Thank you very much, Lisa. We have a few questions for the panel this morning. And, Gorman, that's working with Tyler, are also going to chime in with some of their -- some of their questions. What I'd like to do is to -- pardon me -- is to open up the questioning, and then ask one carrier in particular to take the lead on particular questions, and others can chime in as well.

But let me start with provider payment reform. In general, unit cost continues to get most of the attention as one of the primary drivers of overall health cost increases in New Hampshire, and, frankly, all across the country. Do you think the New Hampshire Insurance Department, or other state agencies, for that matter, should be involved in regulating provider payment policies? And, what I'd like is if Anthem could take the lead on that question, please.

MS. GUERTIN: I would agree with you wholeheartedly that this is one of the most important things, and I think we all recognize that. Throughout

health care financing and delivery, I think the fee-for-service world that we've been operating in is not helping our cost challenges. And, I think we're all anxious to get to a point where we have different payment methodologies in place, not just from a carrier perspective, but I hear from that the providers in the system as well.

I hope that the Department can enable that. I have not thought about a scenario that would have that being regulated. I think that we are very good in this state at convening, we have a number of different organizations that bring various stakeholders in health care together to talk about constructive -- constructive ways to achieve our common goals, and, in some cases, our conflicting goals. And, I see Jeanne Ryer there in the audience, and, certainly, the work of that group is a great example.

So, I'm not trying to dodge the question. I have never thought about a regulatory -- some way that it might be regulated that I think would accelerate our progress in this area.

And, I'm not sure if any of my colleagues up here feel differently.

MR. NGUYEN: I would definitely agree

with Lisa. There might be things that the Department can help to move in that direction. I think the trend is already moving in that direction. Elevate Health is a good example. So, that is a very good example that the environment is already changing.

MS. GUERTIN: And, actually, one other thing I probably should have referenced. I talked about Jeanne's work with her group. The fact that we've worked hard, you've worked hard, to get to the point where we have that all-claims -- all-payer claims database, to me, it becomes one of those foundational things that allows us to really understand what's going on and to be able to look across the system. So, I think leveraging the work we've already done and some of the requirements that have already been put in place has a lot of upside opportunity. And, I think about, again, that, more than any new specific regulation that might -- might help us.

CMSR. SEVIGNY: Good. Thank you, Lisa. And, believe me, I wasn't suggesting that the Department get involved in regulating provider payments.

MS. GUERTIN: Maybe I was just being paranoid.

(Laughter.)

CMSR. SEVIGNY: But we're the first ones

to get the questions. I can't tell you how emails, calls, *etcetera*, that I have received over the past two or three weeks now, where we don't have any authority to do anything, yet, we're looked at for -- to do something. So, I thought I'd at least ask you to weigh in with what your opinions are with regard to that.

Does anybody want to chime in on that comment?

MS. GORMAN: I have comment.

CMSR. SEVIGNY: Yes, please.

MS. GORMAN: So, we all agree that the provider payment reform is a solution that the nation is gearing towards. But that is a long-term solution. And, what I just heard is 5 to 6 to 7 percent unit cost increases that are going to be expected in 2013 and moving forward. Is there any short-term solutions that you can think of? Because, again, we've hit reform in Massachusetts, we're doing provider payment reform. It's been going on for a few years. We are not seeing it yet, and it's going to be a while until we do. So, is there any comment that you can make in regards to that?

MR. GILLESPIE: Commissioner, if I might? Just, again, this conversation comes up lots of different places in the nine states that I cover. And, I

don't believe that there is a quick fix. And, as my colleagues had just mentioned, we're all engaging in provider payment reform. Here, at Cigna, we've been engaged with Dartmouth-Hitchcock since 2008 in a collaborative accountable care arrangement, and with the Granite Health Network for over a year. But this is like turning a battleship nationwide. And, I don't know if there is any quick fix, respectfully.

And, again, the question comes up, particularly, when I talk to state officials, local officials, about how they're going to leverage local costs, and do they bid it this way or do they deal with the broker that way, and how do they, you know, self-funding insured? The best way to lower costs over the long term is to improve the health and wellness of your employees, whether you're a public employer or a private employer.

And, one of the things about the Freedman Report, that I thought was an excellent example, was the Hitchiner Manufacturing, which was pointed out here as creating a culture of health and wellness for their employees. They're a Cigna customer. And, we have a self-funded arrangement with them. And, they've got lots of skin in the game. And, they're doing a lot to

improve the health of their employees. And, I would submit, over the long term, that's the best way to reduce costs.

MS. GUERTIN: If I can just follow on? I think I may be slightly more bullish on it. You know, I know that there's no "quick fix" or "magic bullet" in health care. We know that. But we've already got 40 percent of our delivery system enrolled in some sort of either ACO or the Patient-Centered Primary Care Program. So, that's really significant. Patient-Centered Primary Care just rolled out at the start of this year. And, one of the reasons I think it's so important is ACOs are powerful, but not everyone is a Dartmouth-Hitchcock. And, so, it was really important to find a way to bring the benefits of payment reform to the smallest practices. The Medical Home Pilot that took place around the country, and especially here in this state, have really very impressive results; on better outcomes, happier patients, lower costs, fewer ER visits. And, so, it was really important to figure out how to take that very quickly from a pilot mode to something broader.

So, I do think we will see results. Again, I don't want to say that this is going to turn things around completely. But I actually do think it is

going to start showing results soon, I think it will also help with primary care access, and will really help those practices to practice the way they wanted to when they went into medicine to begin with.

CMSR. SEVIGNY: Thank you. And, that leads me, as a matter of fact, you've really started to answer the next question I was going to ask, both you, Pat, and you, Lisa. And, that was going to be surrounding the payment disparity over certain kinds of procedures. And, one of the more popular ones, I don't know if it's a popular procedure, but ones that we point to, is a colonoscopy. It can vary anywhere from $1,500 to $5,000, depending on what facility you go to. And, Lisa, you started to talk about "site-of-service" and that sort of thing, and, Pat, you alluded to some of the agreements you've got.

Certainly, once again, the push-back, when it comes to site-of-service or those sorts of things, comes to us at the Department. Do you have any words of -- sage words of advice on how we should handle those?

MS. GUERTIN: I don't know? Tu?

MR. NGUYEN: No, go ahead.

MS. GUERTIN: No, I seriously just don't want to hog the microphone. So, if you'd like to say

something first, feel free. But I will take that question.

MR. NGUYEN: Go ahead.

MS. GUERTIN: Okay. I would just say that we recognize the inherent friction in an approach like that. And, I'll relate it back to, again, something that the folks from UMass said in their presentation. We've already got not only the second highest premiums in the country, but we are way up on the list in terms of size of deductibles. And, so, just increasing those deductibles when employers said "I have to do something. I need some relief on these premium increases", we knew we were at the point of no return on these front-end deductibles just getting larger and larger. And, so, this differentiated cost-share that reflects cost differences in the system, and simply passes that through in cost -- cost-sharing to the member level, was, I think, a very necessary and appropriate next step. And, hopefully, in my testimony, you've heard about that, how that has started to help control costs in all ways. So, unit cost, as well as, you know, mix of services, *etcetera*.

So, again, I think it is not perfect. I do think, in this world we're in right now, it simply reflects the cost structures that are in place, without

judging why they're in place, it simply allows the member to become more savvy to those cost differences, and to have their cost-share follow along. We have expanded it. It is now in our Small Group book of business across the board, because of the positive impact it had on the premiums. And, we add new services. So, you mentioned, you know, the difference in price in colonoscopy. A service like REMICADE, an infused treatment, adding that to the list and moving that into private settings has had a tremendous cost impact in that category.

So, I think these approaches, until we can get to a world where payment innovation is fully rolled out, I think they're here to stay for now. And, hopefully, this kind of testimony helps understand why that's true, even though they are imperfect.

CMSR. SEVIGNY: Okay. My next question is about provider consolidation. And, I'm going to ask MVP to take the lead on answering that. But, certainly, all of you are going to be welcomed to participate in the response. One of the arguments for provider consolidation is that it promotes efficiency, coordination of care across the system. In your opinion, does provider consolidation lead to a reduction in costs or prices in overall system?

MR. LOPATKA: In my opinion, no, it does not. And, where that -- what's informing that opinion is the Massachusetts experience. Where there was consolidation, and then there was very comprehensive reports that came out. What happens when there's just two or three big, huge systems? And, what can they do then, in terms of the negotiations? And, what kind of leverage and power will they have when they're negotiating with carriers? It's a mess. So, when the consolidation comes in, it improved their ability to negotiate, which means higher reimbursement rates. So, that's, in my opinion, on provider consolidation, where you just have a couple of huge systems, does not, in and of itself, decrease costs.

CMSR. SEVIGNY: Yes, Pat.

MR. GILLESPIE: Commissioner, we -- you know, I cover different marketplaces for Cigna. So, we see it in lots of marketplaces, where you have mega hospital and provider systems. And, as my colleague from MVP mentioned, the leverage that they can exert in the marketplace is significant.

For those of you who have been to Pittsburgh lately, you see it's all-out war between Highmark Blue Cross & Blue Shield, and the University of Pittsburgh Medical Center. Ads on TV, newspaper ads,

legislators, it's, you know, it's a war out there. And, it shows you that customers expect to have certain hospitals in their network. Customers expect to have certain providers in your network when you're selling to them. And, again, as these systems grow, you know, it's additional leverage that they can use against all the carriers, in terms of negotiating.

There's also another announcement just in the past week in one of the markets I cover. There are 25 hospitals now banding together in a group called "AllSpire", which is going to cover three states, New York, New Jersey, and Pennsylvania. And, again, they're not looking at an all-out merger. But, the fact that there are so many hospitals now in this new agreement, this new arrangement, it certainly raises antitrust concerns or antitrust questions, we'll say.

But, again, just to echo what my colleague has said, when we see, you know, huge facilities, huge branding facilities, the leverage that they can exert in the marketplace is substantial.

CMSR. SEVIGNY: Anyone from the Department or Gorman?

(No verbal response)

CMSR. SEVIGNY: Thank you. Transparency

of costs, and, for that one, I'm going to ask you, Pat, from Cigna, to respond first. In which areas do you feel that health care cost transparency has the greatest potential for favorably impacting health care trends? And, in addition to that, who should be primarily responsible for improving transparency?

MR. GILLISPIE: Can I plead the Fifth on the second one, and just answer the first part of the question? Well, at Cigna, we certainly pride ourselves on transparency. And, we think that informing consumers of cost and quality, so they can make active and informed choices about their care. That's the model that we strive for. And, we've made significant investments nationwide in terms of providing transparency tools for our customers.

And, we view that as our role. Because, again, even though New Hampshire, the state, has done so much on transparency, it's not the case in other states and in other markets. And, again, as a national carrier, we believe, to serve all our customers, we've invested in and created national tools.

So, for example, in 2012, InformationWeek cited Cigna's costs and qualities tools as one of the Top Ten Innovations of the Year. The American

Medical Association cited our transparency tools, just this past year, as providing the lowest cost per claim rework among national carriers. Our customer website, *MyCigna.com*, matches up physician pricing information, facility pricing information, quality information with our Cigna Care designations. We've got information there related to facility and provider for our customers for over 200 common procedures, which represent 80 percent of our claims. And, we match that up to our customer's benefit design. And, if you want to go on line and tour the site and see some of the capabilities, you click on *MyCigna.com*, and go under "Site Benefits". We've also provided these online tools for mobile applications for iPhones, Android phones. And, we've also got a Customer Service Hotline that operates 24 hours a day/7 days a week/365 days a year. And, again, the goal is to serve our members, and recognize their unique nature, is to provide actual information when they want it and how they want it. And, we help, you know, improve their health and wellbeing that way to fulfill our mission statement. And, we view that as primarily the tool of the carriers. And, that we believe it is fair game for competition that, when we go to compete with Anthem, Harvard Pilgrim or MVP, we demonstrate these online tools, and show our prospective

customers that we do this better or we believe we do this better than our competitors. And, that's Cigna's approach to sell our value proposition, not just here in New Hampshire, but nationwide.

CMSR. SEVIGNY: Good. Thanks, Pat. Anybody else want to comment on that at the moment?

MR. NGUYEN: I do want to comment on that one.

CMSR. SEVIGNY: Yes, please.

MR. NGUYEN: At Harvard Pilgrim, we do, and it's very similar to Cigna, we have the savings programs, where members can go in there and put in certain procedures. And, then, the nurse would recommend them where to go for low cost. And, in return, they would have some kind of incentive, rewards for them to use the tools. We also just recently rolled out now, I know, where the members again can put in, like procedures that they would like to go, because now the deductibles are very high. So, if they can go to a low-cost provider, they don't have to pay more deductible, and, at the same time, less co-insurance.

CMSR. SEVIGNY: Thank you.

MR. BRANNEN: Pat, what are the incentives for the member to actually use the lower-cost

setting?

MR. GILLISPIE: It could depend on -- it could depend on the product that they're in. And, in certain markets, we're able to tier products with a Cigna Care designation offering. So, there could be a financial incentive for the -- for the customer to use a lower cost, you know, to use a lower-cost provider.

MR. BRANNEN: What kind of financial incentive?

MR. GILLISPIE: Trey, I don't know if you know offhand if there's an example we could give. But, again, it depends on, you know, the product design and what's, you know, what kind of a plan that the customer is enrolled in.

MR. SWACKER: Yeah. The one thing I'd add is that, regardless of whether or not there's a tiered product design, when I say "tiered product", we can differentiate either co-insurance or co-payment for physicians and then specialists. But, even if that doesn't exist, we provide the cost and transparency tools and who are the high-quality/low-cost providers, that's provided to all of our customers regardless of their plan design. So, there might not be an incentive, *per se*. But, if there's a deductible to meet, that means the

customer has to pay that charge out of pocket, if they haven't hit the deductible yet. So, they can still seek out the lowest site-of-service, even without the formal differentiation or tiering.

But -- so, where we do have tiered products for self-funded customers, it's differentiated co-insurance for physicians and specialists, not different upfront deductibles or, you know, out-of-pocket maxes, depending on which facility you go to for major services.

CMSR. SEVIGNY: Yes.

MS. SMAGULA: So, it sounds like each of the carriers have some type of tool available to their customers to help them understand cost or get cost information. But, just wondering if you've, like when we referenced before, a colonoscopy, there can be a difference between 1,500 to 5,000, do you feel like that's generally well known among your members? Do they understand some of the large cost differences, whether it's by the site or the place where they're getting service? And, if not, do you feel like there's, you know, outside of the work that you guys are doing, is there more that can be done? Whether it's on the employer side or by the state or by the providers themselves, to help the public better understand some of these huge cost

differences?

MS. GUERTIN: Yes. I think we're getting there. I think it can be hard to get people's attention even on something like this. I think it's true that the large deductibles and consumer-driven plans in and of themselves created some incentives for people to start looking into the cost differences and using the tools that we all have. It was surprising to us that, in some ways, that wasn't necessarily enough. Because once you've satisfied that deductible and you're out of that, you know, you could theoretically go back to saying "Oh, what's the difference?" And, so, some of our largest self-funded groups for several years have had programs that actually keep an incentive. So, there's the carrot and the stick. This is the carrot that says "if you'll pay attention and go to the more cost-effective place to get this service, you're actually going to get a check in the mail." And, that's worked really well with some of these larger groups. So, we've now put it in place for all of our Small Group as well.

So, I think it takes multiple approaches, a little bit of a carrot and a little bit of a stick. And, I think, through that, we are definitely seeing that we're making inroads. Again, do we have every

consumer engaged and aware of the price differences? Not by a long shot. But, I do think, by chipping away at it with multiple approaches and multiple tools, you can really start to see the impact.

MR. NGUYEN: I can tell you, from my personal experience, I do have an HSA plan that has a very high deductible. So, my wife, when she got an MRI, she actually go out and shop and use the tools now I know that we have, and she actually go out and shop.

CMSR. SEVIGNY: Good. Thank you. We've all -- or, all of you have talked about the cost of care as a significant driver, and some of the initiatives that you've started to address the cost of care. I asked earlier about the Medical Loss Ratio requirement of the ACA, what MLR is, and so on and so forth. Let me ask you to talk a little bit about, regardless of whether MLR is going to impact you as a carrier, but what the -- what the difference -- the impact of the cost of care versus the impact of administrative costs? And, maybe I'll start with you, Tu, seeing as you've been spared --

MR. NGUYEN: Definitely.

CMSR. SEVIGNY: -- till now.

MR. NGUYEN: The cost of care is definitely a major component of the premium rate increase,

because the MLR, like Harvard Pilgrim, we only targeted less than 85 percent MLR. So, the bigger portion of the cost is the cost of care. So, if the trend increase higher, definitely it going to create problems. So, in order to address some of the problems, the Elevate Health is a good example that we have, that products we actually have a price saving of, I would say, at least 10 percent.

CMSR. SEVIGNY: Anyone else?

MS. GUERTIN: Sure. What I --

MR. GILLISPIE: Turn it on.

MS. GUERTIN: Oh, it's not on. The way I think of the MLR is this. I mean, we -- we don't see it as a radical change. It's very aligned with what we've always been filing in our rates, what we've been trying to achieve. And, I think every one of us, whether a not-for-profit or for-profit, can point to years when you got it right and years when you got it wrong. I mean, we are trying to forecast costs more than 18 months in the future, when you consider the filing time that you have to get it in before your rates actually go into place.

I think the major thing it represents, it won't change what we file, again, we've always been filing very consistently with that. What it does is add an additional layer of protection for the consumer. If we

get it wrong and didn't charge enough for our rates, any of us, we eat that. That's our loss. But, if we get it wrong in the other direction, and we charge too much, because we thought trends -- costs would go up more than they did, that's when a rebate comes in and you actually give that back to your customers.

So, it really isn't changing what we're trying to achieve. What it does, though, again, is create that additional layer of protection that says "you give it back if you accidentally made too much", is the way I think of it.

MR. SWACKER: And, I would just add to what Lisa said --

(Court reporter interruption to identify speaker.)

MR. SWACKER: William Swacker. Sure. And, so, I would echo that we are a for-profit carrier, and it did not change our rate filing as we went back and looked. We were compliant with the expectation that we would be at or about 85 percent. But, again, that crossed -- you know, we have paid rebates in the past, you know, in 2011 and 2012. And, we weren't favorably surprised by the utilization trend, and that resulted in rebates for certain states and certain blocks of business. But, as we

have priced it on a forward-looking basis, it's not with the expectation that we'll pay that rebate. There's a layer, an extra layer of protection.

CMSR. SEVIGNY: Just to make sure that it's clear in the report, what that translates to is that 85 percent is what needs to be spent on cost of care, which leaves only 15 percent to be spent on administrative costs or profits or anything else, broker commissions and so on and so forth. Again, that's so that there's a clear understanding of, if you're trying to impact anything, the 85 percent is probably what should be focused on.

MR. BRANNEN: I've got just a general question. I think I'll direct it to Tu and Lisa. One of the changes relates to the ACA's, the Risk Adjustment Mechanism, which theoretically should protect carriers that end up with a sicker population, and not favor carriers that end up with a healthier population. Can you just comment on how you considered Risk Adjustment in your pricing assumptions, and how significant that was?

MS. GUERTIN: So, you're talking about our Exchange and shop products?

MR. BRANNEN: No, I'm talking about Small Group and individuals generally.

MS. GUERTIN: Small Group and

individuals generally. You know, he doesn't have a microphone and hasn't been introduced, but our Pricing Director, Ken Ehresmann is sitting right there. Ken, do you want to comment?

MR. EHRESMANN: Yes. Thank you, Lisa. My name is Ken Ehresmann, Pricing Director at Anthem. And, thank you, Commissioner. Tyler, to answer your question, "how is Risk Adjustment incorporated into pricing for 2014?" We, because of the unknown factors of how the Risk Adjustment Factor -- or, how the Risk Adjustment Program is actually going to play out, regardless if we already have the formula of what they anticipate, we basically made the assumption that it's going to be efficient, and, so, therefore, no risk -- no pricing adjustment was made because of Risk Adjustment.

Now, at the end of the year, what we're expecting is, just like you said, if one carrier gets a disproportionate share of high risk, the carrier with the low risk would then be tracked and we would go from there. In future years, if we see there are inefficiencies with the method, then we'll address pricing at that time.

MR. NGUYEN: For Harvard Pilgrim, very similar to the way Anthem handled it. However, what we did was, we found -- used the reports that you publish I

think at the beginning of the years, and, based on that reports, we take some consideration into our pricing.

MR. SKY: Commissioner?

CMSR. SEVIGNY: Yes, David.

MR. SKY: When I heard -- I sort of appreciate the discussion about MLR that you've introduced, Commissioner. And, I've been thinking about this, the two components. And, if -- I think, I guess my assumption is that MLR has been relatively constant, your medical loss ratios have been relatively constant over the past recent years. But, if the portion of health care cost is increasing, like you say, you know, in the upper single digits, the only way that MLR could be constant would be if the administrative costs were increasing as fast as health care costs. Otherwise, I think you'd see the MLR start to trend higher, because the administrative costs, as a portion of the overall, would take up a smaller piece of the pie.

And, I guess I was wondering if you could speak to, you know, I guess that assumption, that your administrative costs are growing as fast as health care costs or why are MLR ratios so, you know, relatively constant over the past recent years?

MR. LOPATKA: I mean, I can take that

one. But the other component there is what else is going up is premium. So, you stick at your 85 percent. And, so, your underlying costs might be going up 7, so is your premium. So, you're going to have a constant MLR over time. And, having this, and I agree with my peers up here, that it's a good protection for consumers. And, it doesn't significantly affect our pricing strategies, at least for MVP.

But what's happening is, you can look over the years and it's a constant MLR. But costs are escalating, both medical costs and premium.

MR. NGUYEN: David, one of the component that you may want to consider is the buydown. Even though the premiums are going up, members are also, as well, all groups, are buying down.

MR. SWACKER: Right. I would just want to add there. When we looked at our observed trend, that of benefit changes or buydowns, it has been in the low to mid single digits or has the revenue increase to the claim costs. You know, certainly much lower than for the forward-looking trend, or what would happen if customers or employers did nothing to address the rising medical costs. So, that's held down the net effective trend. So, it's been closer to the administrative cost.

And, then, I would also add, in the Large Group space, we are, you know, if a client isn't self-funding or in a participating arrangement, we are experience rating them. So, whatever their trend might be or their jump-off point, use that to set the next year's premium. So, it does -- you know, that could reduce some of the volatility in the loss ratio --

(Court reporter interruption.)

MR. SWACKER: -- socialized rates. I'm sorry. That could reduce some of the volatility or year over year change in the loss ratio.

CMSR. SEVIGNY: Other comments or questions?

MR. BRANNEN: Yes.

CMSR. SEVIGNY: Yes.

MR. BRANNEN: If I could direct this to Pat. You mentioned a bit about the ACOs and the work that Cigna has done in this area. But you also mentioned that there's a neutral pricing assumption for members enrolled in the ACO. I realize you've got a relatively small population in New Hampshire, but Cigna obviously has a large population nationally. I mean, there are clearly expectations that ACOs will improve quality, but there's also a real hope that they're going to do something to

cost. Can you just comment on whether or not you've done the analysis and come to the conclusion that it's a neutral cost change? Or, can you just say anything more about that?

MR. GILLISPIE: Yes. I might ask Trey to weigh in on it as well. But, with Granite Health Network, which is one of our newer CAC arrangements, it's only a year old, and, although we have a pretty substantial membership block that's participating in that arrangement, I don't know that we're at the point where we can observe a trend or a cost deflection. It is our belief that, over the long term, it certainly will. But, Trey, --

MR. BRANNEN: Or anywhere else in the country, too, I mean --

MR. GILLISPIE: Yes.

MR. SWACKER: Sure. And, I can comment nationally. We've had 12 ACO arrangements nationally. Dartmouth is one of them. They have been around for I think three years or more, at least two years or more. And, across those, over their lifetime, we have seen them deflect costs by more than what we pay in terms of care coordinator fees or, you know, fees to enable them to hire the staff to look at the extra data that we provide. So,

it has had a modestly positive cost impact. But, within there, there's fluctuations. So, some have worked very well and beaten trend by, you know, three or four points. Some, you don't see the trend deflection, or it happens to be higher than the local market. So, within those, the next step is figuring out, you know, what caused the relationships that worked to work, and is it something we could do better or, you know, in terms of partnering with providers and how they're going to use the data or how they use the data to provide it most effectively, is there anything that we can encourage? And, we do try to convene those stakeholders or, you know, the provider groups that are in an ACO, we try to convene them so that they can share best practices or the ones that are working. Had good success with one in Atlanta, and one in Texas as well, to make sure they chose best practices. And, now, we have over 60 nationwide. So, 50 of the 60 have been around for 12 or 24 months. And, for a lot of them, it's too soon to tell. But, making sure that they're doing the right thing and learning from the experience of others.

MR. BRANNEN: Thanks.

CMSR. SEVIGNY: Okay. We'll take a short break, finish up with any remaining questions for the carriers, and then move right into the non-carrier

speakers. So, why don't we take about ten minutes, which would put us at about five after 12. Deb, maybe you can tell folks where the facilities are.

(Recess taken at 11:56 a.m. and the hearing resumed at 12:13 p.m.)

CMSR. SEVIGNY: Thanks a lot, everybody. Okay. I want us to continue the hearing pretty much where we left off. We'll finish up with questions that we may have of the carriers, and then move on to the non-carrier speakers. John, I think you had a question earlier. I don't know if you still have it, or a comment or --

MR. CAMIRE: Yes, I have a quick question. I guess it's kind of around the concept of transparency. But the whole discussion about different product innovations was referenced in the UMass/Freedman Report, and then some of panel here have mentioned some of the various types of products that they're rolling out and offering in the New Hampshire market. And, just wondering, you know, the additional challenges, now that provider -- or, excuse me, product innovation is not just, you know, adding another deductible level that's $500 higher than it used to be, but now involves different network designs, potentially tiering, potentially other complexities that are new to consumers that, we've already

talked about, are very price-sensitive. So, they see the lower price and they're attracted to that.

But what are you doing, and, you know, there's probably any number of you can take this on the panel, but what are you doing to make sure that your customers, whether they be employers or their employees or individual consumers, really know what they're buying, and providing that transparency, in terms of the additional responsibility, in terms of provider choice and other cost responsibilities, when they make a choice that might be partially price-driven?

MS. GUERTIN: Yes. And, I'll just paraphrase a little, to make sure I'm on point with my response. So, with all this change and with all this complexity, how are we making sure that consumers don't just have transparency into price, but transparency into their benefits and what they're buying? Is that right?

MR. CAMIRE: Yes.

MS. GUERTIN: Okay. Well, I think there's a few things. And, one is we've, I don't know if you'll think this is a good thing or a bad thing, but, under the ACA, we are all more consistent now in how we present benefit information. It's long and it can be complex, but it's consistent. So, I think, in some ways,

that's good. And, as people potentially begin to use the Exchanges and those portals for information, you know, it's another way to compare and contrast.

But I think most of it still falls to us, as insurers, to figure out how we can educate. And, I think, if you look at our online tools, for instance, and I'm sure others can cite similar things, it isn't just about "Hey, look through your benefits, and figure out what this service costs at this facility." It's "What will your cost share be with the plan that you might select", or even "What kind of plan would be right for you? Are you the kind of person that would rather pay a little more every month and have a little more certainly of your future costs? Or, would you rather have a better bargain on your premium and pay more in the future?"

So, I do think our tools on benefit choices and designs hopefully are keeping up with that. I think we're trying, and I think consumers will tell us if they get it. And, it is very important. I think you're calling out a very important aspect of all this change.

MR. GILLESPIE: I think, you know, for us, for Cigna, we have health engagement managers, customer engagement managers. And, we offer a wide variety of services to our employer customers. And, what

we found a lot of times is that it needs to be the employer themselves to drive a lot of these things, because their employees aren't necessarily going to respond to an insurance company, they're going to respond to their boss, or to their CEO or their chairman, or whomever.

And, as a result of that, we have folks who regularly go out and visit with customers, visit with their employees, do health and wellness seminars that interact with their benefit plans and their plan designs, talk to them about all the different Cigna services that we have available on the health and wellness end, and, again, trying to interact it to whatever they purchased, in terms of a plan. And, we view it for employers, who buy into the value proposition about creating a culture of health in there amongst their employees, we provide an extremely wide variety of services. And, that's the value prop that we try to push.

Again, not to be repetitive, but, over the long term, we think the best way to improve your cost is to improve the health of your employees.

MR. NGUYEN: The New Hampshire market is pretty much a broker-driven kind of market. So, whenever we roll out products with some kind of innovation, we're

making sure that we train our broker well, like how our products works. And, then, hopefully, in return, that they, whenever they're going out and they sell to the employers, they would be transparent about the products that we have.

CMSR. SEVIGNY: Yes, Jenny.

MS. PATTERSON: I guess this is really a question for Lisa, and kind of a follow-up on what you said about Anthem's online tools. And, I'm wondering, you know, we talk about the employer market being broker-driven, and I think, to some degree, the individual market as well. But how usable do you think those online tools will be and how well will they work in conjunction with the marketplace, in particular, for consumers who are going on as individuals, who may not have gotten health insurance in the past?

MS. GUERTIN: Yes. Well, I think, in general, if you just think about our own tools that we put in place, without worrying just yet about linkage to the marketplace or the Exchange, I think we've recognized that we have to get a lot more consumer-oriented, with a lot more direct-to-consumer, even inside of a group. We have to have tools that people are used to in all other aspects of their lives. Their -- you know, every other sort of

aspect, whether it's banking or, you know, private finance, whatever, they want tools. And, so, I think someone mentioned earlier, mobile apps have become increasingly important. Mobile ID cards is something we offer. I mean, it really has moved very quickly over the past couple of years. And, that includes Provider Finder. If you need help finding an urgent care center, because your benefit says that, you know, you're going to pay less going to an urgent care center than an emergency room, you need that instantly.

So, I think a lot of it, once again, falls on our side of the line. And, it's all about us keeping up with our customers' demand, which is one of those things we compete on.

I think that, for us, in particular, on the Exchange for next year, that interface with the Exchange, with the marketplace, is going to be really important. And, there are things you can do on our site, like, for example, let's use our individual products. We'll have both individual exchange and individual off-exchange products for sale. On our own shopper portal, you'll be able to compare and contrast those plans and those prices. You'll be able to estimate what you might get for a subsidy, but you won't be able to get your

final calculation. For that, you'll jump over to the actual federally facilitated exchange, and that's where you will determine your subsidy and enroll in the exchange plan. So, there is going to be this new degree of integration, required of us, starting in 2014.

CMSR. SEVIGNY: Other comments from anyone?

(No verbal response)

CMSR. SEVIGNY: Okay. Good. Well, thank you. I am going to ask you to persevere up there for a little bit. And, we will go to the non-carrier speakers. We've got several who have asked to speak during this hearing. And, let me start in the order that I have them. I'm not certain that everyone who initially signed up is actually going to speak, but I will ask you anyway. Amy, do you have any words of wisdom for us this afternoon or --

MS. KENNEDY: I have several, but I'm fine. Thank you for having me and allowing me to be here to listen.

CMSR. SEVIGNY: Amy is from the Governor's Office. And, I'm sure will report back about this hearing very -- very well. Thank you.

Next is Tom Bunnell, from New Hampshire

Voices for Health. Tom, do you wish to address us this afternoon?

MR. BUNNELL: I'd be happy to. Do you want me, should I --

CMSR. SEVIGNY: Please. Please, if you would. Although, I won't have you do it the way David Sky suggested, and that's on one leg. You can stand on both, if you'd like.

MR. BUNNELL: See if I can do this. Thank you, Commissioners and staff. Better?

FROM THE FLOOR: Yes.

MR. BUNNELL: Good morning. I guess it's "good afternoon". And, thanks for this opportunity to provide you with testimony on premium rates in the health insurance market. My name is Tom Bunnell. And, I'm a Consultant and Health Policy Specialist with New Hampshire Voices for Health, also known as "Voices". We're a nonpartisan statewide network of organizations and individuals allied in the commitment to quality, affordable health care and coverage for all residents of New Hampshire.

New Hampshire families and businesses, I think as you've heard so much this morning, are continuing to struggle to afford combined cost of health insurance

premiums and with benefit packages weakening across the board, out-of-pocket costs and charges for health care services. For insured employers and employees, these combined costs have continued to rise faster than inflation, faster than wages, faster than average business profits. It's important to note that these cost trends were present and in dynamic play long before the enactment and any beginning implementation of the ACA, which is more commonly known these days as "ObamaCare". Unsustainable increases in the combined cost of health care and coverage, destabilized budgets for families, employers and government at all levels in our state, and threaten all of our financial stability.

For these reasons, and since New Hampshire has some of the highest health insurance premium and deductible costs in the nation, as you also heard this morning, health care and coverage costs are a nonpartisan issue in our state. They are an issue that transcends partisanship in our state. And, they're a matter of great concern to policymakers, to consumers, and to business community all over our state.

So, we are grateful to the Department for your transparency and information efforts, efforts that have made information about health insurance premiums

more available to the public and to all players. We think that information is beneficial to public understanding and dialogue. But that there is more to be done in that context. And that, in particular, health care cost component of health insurance premiums is something around which we believe that more transparency is appropriate and necessary. So, we would encourage you to support or employ efforts that provide mechanisms for health care cost and quality and utilization data to be available to all, and to members of the public, to policymakers, to carriers, to health care providers.

None of us believe that the availability of information or the transparency will in and of itself or by itself result in any health system's changes that may be needed. But they are, in fact, a sensible and appropriate building block step for understanding, and for any and all of us, including policymakers, to make effective and meaningful information-based decisions about health systems.

That said, we also think -- hang on for one second here. In our view, the most important and promising arena for health systems change involves payment delivery system reform. We applaud health insurers and health care providers that are engaged in early and

ground-breaking efforts seeded and encouraged by the new federal health law that are aimed at such reforms, to realign incentives, to promote value and quality, to coordinate care, and to improve health outcomes, while also improving efficiencies, that hold promise for lowering costs. And, as we heard some this morning, an example of those models including -- include health care organizations, Patient-Centered Medical Homes, risk-sharing arrangements between insurance carriers and hospital systems and other health care providers, and/or global payment or pay performance kinds of models. There's great promise in these emerging models, with a great deal more to be done, of course.

I guess our health care system is beginning to embark on a complex and critically important, long-term journey in this arena. And, one notable challenge is that emerging payment and delivery system model and innovations exist at the touchpoint between health care as a business and health care as a public good. There is a genuine and meaningful role for government, as an honest broker for the public, and at key and select and necessary times, as a regulator for the public interest in that context.

And, so, we urge the Department to

consider employing a range of ways to support and to further promising payment and delivery system reforms. Consumers and businesses and policymakers are increasingly interested in this vein, and are anxious about precisely these types of value-based improvements in our health system, that promote quality, that share savings, and that help to bend the cost curve. Payment delivery system efforts, with active consumer and business community engagement, can be improved and need to continue to be employed and to grow.

I will just say that we are confident that health insurers and health care providers in New Hampshire understand that the cost trends in health care coverage are not sustainable. We're also confident that they want -- they all want to be good citizens. Value-based purchasing and transparency are merely components of that good citizenship obligation, and the responsiveness and accountability to customers and the public at large.

So, the Department's rate review process and efforts are, we think, meaningful building block steps, as all of us aim for a health care system that is more rational. And, we thank the Department for this process and for your attention to these matters. And,

would be happy to continue to collaborate with you in whatever ways may be helpful. That's all.

CMSR. SEVIGNY: Thank you, Tom. Any questions from anyone? Comments?

(No verbal response)

CMSR. SEVIGNY: Thank you. Next, I'd like to ask if Paula Minnehan, from the New Hampshire Hospital Association, would like to provide us with testimony this afternoon?

MS. MINNEHAN: Good afternoon. And, thank you for this opportunity. I'm Paula Minnehan. I work at the New Hampshire Hospital Association. And, my comments are -- I used the report, which I think was excellent, and not just because we were interviewed for the report, but I used the report that Freedman and UMass did, -- and, excuse me, in advance, I have a cold, and I need to go see my health care provider, I think.

(Laughter.)

MS. MINNEHAN: I have a really good one in town. So, that's good. As a template for what I wanted to comment on. And, one issue that was highlighted early on had to do with out-of-pocket liabilities for patients. And, New Hampshire's average deductibles, as was stated by Missy earlier, is that our deductibles are

25 percent higher than Massachusetts, and almost double those of deductibles in the United States. This has a direct impact on providers and their uncompensated costs, and specifically hospitals, because they need to meet those deductibles for most inpatient and outpatient hospital care.

But, having said that, hospitals do work every day to reduce costs in a variety of ways. Hospitals have had to reduce their workforce in the last couple of years to address falling reimbursement rates and higher uncompensated care, which has resulted in more uninsured and underinsured individuals, for among other reasons. More than ten of our acute care hospitals had to reduce their workforce significantly in the last couple of years. They had to reduce employee benefits, close clinical units, and had to change their generous charity care guidelines to be more in line with the industry norm.

In addition, though, which is on a positive note, 100 percent of our New Hampshire hospitals are engaged in the CMS Partnerships for Patients. And, none of those data points that they use are from claims data, they represent significant or specific quality-oriented outcome measures. New Hampshire has estimated cost -- excuse me, has been signaled -- singled

out by CMS and IHI for their success with Partnerships for Patients. To date, the estimated cost savings are approximately $3.8 million achieved through improved patient care, and specifically with reduce falls, reduced infections, reduced readmissions, patient ulcers, *etcetera*, since 2011. These efforts continue in all hospitals, and we believe more savings will be realized in the coming years and ultimately result in better patient care.

It's important to note that the readmission reductions for Partnerships for Patients impact all patients and all payers, not just Medicare patients, even though it's a CMS initiative. Savings go directly to the insurer. And, we believe future reimbursement models should reflect these benefits on both the provider, as well as the insurer, because, with reduced readmissions, obviously, there's no claim that results. Which is -- that's not the point. The point is the patient does not get readmitted, which is good.

One other issue that I think needs to be clarified in the report. I think they were using older data, because that's all they had. But our latest data shows the hospital system margins, and we and Steve Norton ton is well aware of how we now compute hospital system

margins. It's not just the hospital, but all -- all associated affiliates that they are responsible for, are at an all-time low of 1.2 percent, with seven hospitals currently in negative -- having a negative margin. What many outside hospital industry -- what many outside the hospital industry don't seem to understand is that hospitals operate many of these service lines at a loss, including emergency rooms and physician practices. While there's a cost to employing physicians, there's a positive trade-off of better alignment with their EMRs and overall clinical integration. It can result in better outcomes and increased efficiencies. However, hospitals do try to recoup some of those costs by developing provider-based reimbursement models, which are supported primarily by Medicare. The idea is that there are measurable costs associated with the integration of physician practices into the operations of hospitals, and Medicare primarily recognizes these costs.

Cost-shifting, which I won't take Steve's thunder, because he's responsible for the cost-shifting report. But we do believe that there -- that we would contend that cost-shifting does occur. In New Hampshire, Medicare reimburses our hospitals about 85 percent of their allowable costs. New Hampshire

Medicaid reimburses our hospitals at approximately 50 percent of allowable costs. These two government payers make up over 50 percent of most hospitals' payers mix. And, it would be impossible for a hospital to continue its operations without attempting to mitigate these shortfalls by negotiating higher reimbursement rates from private payers. However, that's not a sustainable model, and, in fact, many hospitals are attempting to move away from the current reimbursement model to accountable care-type organizations -- organization-type models. However, current reimbursement systems are not aligned to support their goal to -- in achieving efficiencies in clinical and operational integration. There are a number of examples of innovative health reform models already in place throughout the state that should be expanded and replicated where possible. The New Hampshire Citizens Health Initiative Accountable Care Project is the perfect example, as is the Dartmouth-Hitchcock ACO, which has already been referenced.

But I think it's important to note, and I think it's because the -- because of this, the benefit design as site-of-service and limited networks work in counter purposes for this. And, what happens is, with site-of-service, it is almost -- it's like cherry-picking

some of the services that the hospital actually was able to make a little bit of money on, i.e., laboratory and ambulatory surgery center care or outpatient surgery, by cherry-picking those away from the hospital, they still have these costs associated with covering the emergency room, covering inpatient care, which, in some -- in some service lines, they actually lose money. So, that's what I mean by "working at counter purposes". That we want to work towards more integration and more accountable care-type models. And, what we are experiencing right now works at cross purposes.

We agree with many of the recommendations outlined in the report regarding the role of the state in health care system development. We believe that we need a state plan, we support transparency and the efforts of the Department of Insurance in this regard. We believe the State should increase its investment in primary care, and the Department could play a convening role in the development of new pilots for payment models.

And, I think some of you know that the Hospital Association has worked many years on increasing price estimate transparency, and which the -- for services provided by the hospital, as well as their ancillary and

professional services provided by the hospital-affiliated practices. We recently revamped our price estimate process hospitals utilize for our members, and our members have established a series of best practices that will be employed by hospitals in the coming months. We do believe that there is a role for the State, as well as the provider -- as well as other providers and carriers, in ensuring that patients are able to obtain reliable and accurate price estimates upon request.

We also believe the Department should support the improved patient -- support improved patient access to health care by updating the Department's Network Adequacy Rules. The current rules are inadequate and have -- and we have two examples of how these rules have been ineffective in ensuring proper access to needed services in many parts of our state. Specifically, with the inception of site-of-service type products and limited networks that exclude entire counties within the state. The state should ensure that access to needed services is available to all populations, and that products are not sold in counties or markets that do not have a provider network that can meet the needs of the communities in which they are selling their products.

To that end, we are interested in better

understanding how the carrier that is offering coverage in the marketplace determine the utilization patterns for the currently uninsured individuals in the state. As many of you know, all hospitals provide millions of dollars of care to uninsured individuals, and have a keen interest in having these patients continue their care with the providers with whom they have established relationships. "What data was used in determining how these uninsured patients could -- would access care?", is just my follow-up -- is my question? And, that's it.

CMSR. SEVIGNY: Good. Thank you very much.

MS. MINNEHAN: Uh-huh.

CMSR. SEVIGNY: Okay. Thank you. Next up is Steve Norton, from the New Hampshire Center for Public Policy Studies. Steve.

MR. NORTON: I don't actually have any prepared remarks, but --

MS. O'LOUGHLIN: Can you go up to the podium?

MR. NORTON: Yes.

MR BRANNEN: And, I'll remind, if this has already been said, this is their opportunity to question the carriers directly.

MR. NORTON: So, I have no direct testimony to share with you. But it strikes me that it's -- we've done a fantastic job as a state in producing information about prices, and -- but we're really using that in some respects, prices and information about things like network adequacy, as a proxy for quality and high-value health care. And, I'm interested, and the way I thought of it while you were all talking, particularly around site-of-service, is we think it's difficult, because we're forcing people to go to different places than they might normally go to. They might agree to go there, if they understood that it was both less costly and also had better outcomes.

And, so, it strikes me, and my recommendation to the Department of Insurance, and my question for you is, how do we move the conversation more to that place, than just on prices? Because it strikes me, we've done a great job there. And, maybe we don't need to spend as much energy there, and spend it more on quality. And, I'll step down from here.

CMSR. SEVIGNY: Thanks, Steve. And, feel free to respond to --

MS. GUERTIN: Are you looking -- okay, now? I didn't know if you were holding them for later to

respond?

CMSR. SEVIGNY: No, I was, but that probably is going to lead to many questions that go unanswered, if we don't answer them in the order that they're asked.

MS. GUERTIN: Okay. So, the question, Steve, is about site-of --

MR. NORTON: Well, --

MS. GUERTIN: Go ahead.

MR. NORTON: No, it's not about site-of-service, but you can use that as an example.

MS. GUERTIN: Okay.

MR. NORTON: We're going down this path, we're talking about the importance of adding understanding, allowing consumers to make decisions, but the real information that they need to be able to be effective is not available to them.

MS. GUERTIN: Uh-huh.

MR. NORTON: And, that is, "it doesn't matter whether I go to Concord or to Manchester, the quality is the same." Or, in fact, "yes, the ones that have a good outcome is better in Manchester than it is in Concord."

MS. GUERTIN: Sure. Yes.

MR. NORTON: So, all they're doing now is relying on their sense of connection to an institution, as opposed to a real understanding of the value of that institution.

MS. GUERTIN: Okay. Sure. Well, --

MR. NORTON: Or any other provider. I don't --

MS. GUERTIN: Yes.

MR. NORTON: I'm not picking on hospitals.

MS. GUERTIN: Yes. So, I think -- I think there are actually a couple of important questions or points embedded in that question. And, maybe the first is we do, I think, all already try to make quality information available, as well as cost information. And, I think we all have our proprietary ways of doing that. You know, for us, we have Blue Distinction, we have Zagat, which is -- it's interesting, when you ask a consumer what "quality" means to them, it's not always the leapfrog measure. Sometimes it's a very, very personal and subjective thing. So, I mean, I think, first of all, we're all trying. I still think it's controversial. I think most hospitals would say "We don't know if we agree with your report cards, or anybody's report cards on

quality."

So, I think you raise an important point, which is maybe collectively we can get to the point where we do agree on those things. And, we do think we have a reasonable, accurate way to look at quality.

I can tell you that, for the site-of-service piece, and whether it helps or hurts sort of that whole continuity of care, I think what that's really about is we've been living in a world where members and employers and providers' incentives weren't aligned very well. I think that, as you begin to get into Accountable Care Organizations, we bring those things into much better alignment.

For example, an employed physician is thinking, you know, "I need to try to keep care, for the most part, within the system in which I operate." And, that's -- that's understandable and it's fine. But an employer or member may say "well, we want to look through that system, and we just want to look at all the sites that are available in this area. And, we want people to be choosing among those based on what's cost-effective."

When you get a practice into a Primary Care Medical Home Program like ours, or like an ACO, it's likely a physician starts thinking differently as well.

And, I hope that, as we move more fully into that world, the kinds of programs like site-of-service become less necessary, because the thinking among the various participants in health care, the patient, the physician, the hospital, are better aligned than they have been before.

And, just to address the question, I know it's not really our focus today, but on the fact that we have a smaller network for the Exchange, we did not tier that based on quality. All of the hospitals in the state are -- participate in our network that serves 90 percent of our customers, and they're all great quality.

What we did do, to address Paula's question, which I didn't understand I was supposed to address at the time, for now, we do have this -- the "network adequacy" is defined. It's not something that we subjectively created, it's defined. And, we used, because we have such a very high market share, and we know where the uninsured people are, we can use those zip codes to run disruption analyses and to figure out how many people were comfortably within those requirements that are expressed in the statute and how many are just within it. And, so, that's how we determined it. It really was a

geographic design. And, maybe, in the future, we should all be thinking about narrowing networks or tiering networks using well-established and agreed-upon quality criteria.

I hope that addresses all of those questions bundled up together.

CMSR. SEVIGNY: Yes. Thank you very much, Lisa. And, thanks for bringing it up, because, again, it points to following the law, basically. I started our discussion early this, well, this morning talking about the fact that I've received an awful lot of communications personally, about this and site-of-service, and a whole host of issues that look at addressing the cost of care, with the misconception, I guess, if you will, that I have far more authority than I do have, and asking me to order carriers to contract with certain facilities. And, I can't do that. And, all of you know that, and neither do I suggest that I would want to either. But there is a misconception out there that there is far greater authority that rests in the Insurance Department that is there, for that matter.

Next up is Mike Degnan, from the New Hampshire Health Plan. Please, Mike. And, again, you can stand on two feet, if you'd like.

MR. DEGNAN: Well, you just know I can't sometimes. So, that's why you say that. Thanks for the opportunity. I think I've testified before this group for the last couple of years. And, I think this is a good time to give a summary of what's going on with the New Hampshire Health Plan, because we are, in fact, will be going out of business as providing health care coverage at the end of this year.

But, just to review quickly some of the facts about our organization. We are a 501(c)(26) not-for-profit voluntary organization. We were established under RSA Chapter 404-G. We are overseen by an 11-person board of directors. We have -- I have four of my Board of Directors here today working. We have six carriers, and five other individuals appointed by the Commissioner. A very active Board, we put in an awful lot of time, and I can't say enough about how much work our Board has done on our behalf.

But, going forward, in the last session, there was House bill 526, talked about the termination of the activities of the New Hampshire Health Plan. So, we will -- we filed a plan termination with the Department in September. That plan has been approved. The plan is available on our website, if folks would like to take a

look at that. Our goal right now is that we will cease new enrollment as of the first of December of this year, and we will terminate all coverage as of 12/31 of this year.

So, our 20 -- today, we have 2,820 enrollees in the New Hampshire Health Plan; our high was 2,875 earlier this year. So, we serve people who really need health care coverage and use our services quite regularly. We were talking about the loss ratios. The loss ratio for the state, the high risk pool, is about 160 percent.

So, NHHP gets no state dollars. We are funded through carrier assessments, premiums, and a small amount of federal grants that we use for our Low-Income Premium Subsidy Program. That Program has been in effect since 2008. And, as of today, we have over 436 of our enrollees are enrolled in that Low-Income Premium Subsidy Program, which isn't very substantial.

We offer seven -- seven benefit plans. We are really a virtual company. We have -- our TPA is an organization called "BMI", in Kansas. We have an actuarial in Colorado. And, there are no employees for NHHP. We do, relative to rate-setting, we do that on a semiannual basis, looking at the standard risk rates in

the individual market. And, by statute, our rates are 125 to 150 percent of the standard risk rates, and -- today, and we have been, for about six or seven years, we have been at the 125 percent level for our risk rates.

So, let me talk about the Pre-Existing Condition Insurance Program, the PCIP Program, the Fed program. That started in July of 2010. And, we were the -- and this is old news to everybody, but we -- and I'm still proud of it, we had the first enrollee in the nation, and we were the first state in the nation to have a contract with CMS. But that program was allocated $5 billion by the Feds. And, they became anxious about spending through those dollars. So, as of March 2nd, 2013, we had an enrollment freeze.

That enrollment freeze led to the opportunity that the Feds gave us in April, they wanted to know if we wanted to continue to administer the Program for the last six months on a full-risk basis. And, the medical loss ratio for this group is -- as of April was 952 percent. So, we were not allowed by our statute to take full risk. So, we terminated our contract with CMS for the PCIP Program as of June 30th.

We were initially allocated $20 million for the State of New Hampshire for this Program. And, by

the time the Program winds down, we're in a 12-month wind-down right now, the State of New Hampshire will have brought in about 62 and a half million dollars that went to individuals who normally wouldn't have had insurance coverage. So, it's been incredibly successful.

We did, I think, another wonderful program, part of the PCIP, was that we allowed third party payment of premiums, and that was very significant. Over 35 percent of our enrollees had their premiums paid by third parties. And, of those, 57 percent of our claims went to individuals whose premiums were paid by third parties. So, I think that's very significant.

Just let me talk about assessments for a moment, near and dear to the hearts of the folks up here. And, Lisa and I have had a lot of talk about this. We are supported by assessments. And, the assessment for -- that we are going to recommend to the Board at our board meeting next -- next Thursday, there will be no assessment for 2014. We had a very high assessment for '13. But we had some extraordinary events that occurred that allowed us to accumulate more money than we had anticipated. So, going forward, the assessment for the New Hampshire Health Plan will not be in place any longer.

The last part of our Program I want to

talk to is about the consumer assistance grant. That you probably are aware that CMS allocated $5.4 million to the State of New Hampshire to do outreach and education, and to hire some marketplace assisters for participation and the start of the Accountable Care Act. Well, about a couple of months ago, in a conversation we had with the Commissioner and with the Governor's Office, it was clear that the Department was not going to be able to -- to get access to those funds. And, they asked our Board if we'd be willing to apply to that grant. So, after numerous conversations with the Department, with CMS, and a lot of work by our Board, the decision was made that NHHP would apply for the consumer assistance grant. The status today is that the money has been de-obligated to the Department, and that we are anticipating hearing about the money being re-obligated to New Hampshire Health Plan sometime in the next three or four days, is what we understand. So, that money is going to be used for outreach and education, and then to hire marketplace assisters to let the citizens of New Hampshire be informed about the Accountable Care Act.

So, we are working aggressively to bring that up to speed. The Department had done a lot of work, and we built on the work that they had done. And, so, we are working -- we have RFPs that have been in the

marketplace and responded to, and we'll be doing some evaluation of those RFPs tomorrow, and presenting that information to our Board committee tomorrow.

So, I think we also -- there's been a lot of other parties in New Hampshire who have done work relative to this consumer assistance grant, and we've tried to partner with them. The Healthy New Hampshire Foundation has done a tremendous amount of data collection, trying to look at how we'd allocate funds, and a number of other organizations have really been working with us over the last six or seven weeks to get this -- get this grant out and make it functional for the folks in New Hampshire.

So, I want to thank the Department for the work they have done with us over the last, from when I've been doing this, for the last six or seven years, and also our Board, all the work the Board has done to make this a real successful program. So, any questions?

CMSR. SEVIGNY: Thank you, Mike. Any questions?

(No verbal response)

CMSR. SEVIGNY: Good. Thank you. Thanks, Mike. Next up is Jeanne Ryer, from the New Hampshire Citizens Health Initiative and the New Hampshire

Institute for Health Policy and Planning. Jeanne.

MS. RYER: I always follow the tall people. So, thank you. As Roger said, I'm Jeanne Ryer. I'm the Director of the New Hampshire Citizens Health Initiative, and also am representing today the Institute for Health Policy & Practice at the University of New Hampshire, which is the Initiative's home now.

As many of you know, and I think you've heard our efforts alluded to in some of the conversations this morning, the Initiative has, since 2005, really set a common table for New Hampshire to bring together our insurance carriers, our providers, business, the public, government, to work on compelling issues of common concern. And, generally speaking, we work in the area above the competitive fray, but where these compelling issues create a climate where all of these stakeholders can come together and try to move these issues forward.

In that vein, we've had several strands of work that we've been engaging in over the years. We are beginning a new project called the "New Hampshire Road Map for Health", which is bringing together population projections, demographic projections, and health indicators, to give us a picture of where New Hampshire's health future is headed, and I think to help develop that

sense of a common shared vision of what our health and health care should look like going forward.

We also have worked to pull the public health and clinical care sectors together in a long and engaging stream of work on health promotion and disease prevention, and most important today is our work on health system transformation and payment reform.

I want to take this opportunity to thank the Insurance Department for all of its work, along with the Department of Health & Human Services, on the New Hampshire Comprehensive Health Information System. It is key to understanding and creating a window of transparency for all of us to try and move the health system forward to what is typically called the "triple aim", and something that we subscribe to. Which is that we can create a system in New Hampshire with better health and better care and lower costs for everyone. In fact, that is what we must do.

Through the work of the all-payer claims data, we have a window of transparency in New Hampshire that few other states enjoy. And, I am the envy at national conferences when I talk about "Oh, yes, we can do that." "Oh, how do you know that?" "Well, our all-payer claims data provides us with that kind of information."

And, my colleagues at the Institute for Health Policy & Practice's Center for Health Analytics help us apply that information to create the shared table, and inform the shared table, where we work with carriers and providers, to try and move our system forward.

The Initiative's Accountable Care Project that you've heard mentioned this morning, brings together the major carriers, Medicaid, and a group of 11 providers and systems, that collectively take care of 25 percent of the commercially insured patients in our state and 30 percent of the Medicaid patients. At this Initiative table, the stakeholders sit, share data, share best practices, and look at analytic results to help them understand what's going on in our health system across all the payers and across these providers, and then try to figure out how to make it better, and how to create truly accountable care going forward.

In our last year, we have gotten to see, with new eyes, that's what one of our members says, "We have new eyes, I have new eyes to see things I could not see before." What the cost and utilization, and eventually soon the quality of the care, is being provided in our state for our commercial, Medicaid, and soon our Medicare population as well.

But, as you've heard today, our -- New Hampshire has high health care prices, we have high health care premiums, we have high deductibles, and we have an urgency to act. We also have, I think, generally, and as across this country, is a pretty healthy population, and pretty good quality of care. But we cannot rest on our laurels, and our demographics are not on our side. We are aging as a state, and personally, and we are aging rapidly.

So, my question to our carrier friends is this: All of your organizations have sat at our table. Some of you have been represented by colleagues. So, you may not be directly familiar with our work. But, as you think about the issues, you know, we've done work with you on electronic prescribing. We've moved the state from 37th in the country, to fifth. We've done work with you on Patient-Centered Medical Home. I think Lisa just acknowledged it probably saved a bundle. And, we're working with you on Accountable Care. What should we be working on next? What is the next big, compelling issue that we can work on together, with our provider community, our hospitals, our primary care organizations, to move our system forward?

And, I -- we want to continue to engage

with you, we want to continue to encourage you to work with us. And, we hope that you will continue to work with the Insurance Department, and having the Department's engagement as well to move this big -- this issue forward. But what is the next big, compelling issue? Where should we go next? Assuming we solve Accountable Care by next spring.

CMSR. SEVIGNY: Sure. Yes. Please.

MR. GILLESPIE: Want me to go first? Sure. So, during the break, I was asked about "what's the cutting edge?", I guess. What's the cutting edge? What should we be looking to do, in terms of trying. And, for us, I think we've invested a lot in trying to get our customers, our members more engaged in their own health. Take ownership, take responsibility for their own health, and understand what their health risks are.

And, Cigna, because we practice what we preach, we, as Cigna employees, all 30,000 of us across the world, have been doing health risk assessments over a period of years. And, the next phase of health risk assessments, not only for Cigna employees, but for Cigna customers starting in 2014, is to use what's called "gamification technology". Online tools, a gamification tool in order to help engage customers in understanding

what their own health risks are and what the alternatives are.

So, what is "gamification"? Well, when I was a kid growing up, the cool video game was Pong. I think they have gotten a lot better since then. But how many people play Candy Crush or Smallville or Words With Friends, all these online games? So, what we've done is we've taken those online games, and we've used it to rework our Health Assessment Questionnaires that our customers and that our employees fill out. We've also reduced the numbers of questions that are on the questionnaire, from 65 to about 30.

And, by using this gamification technology, we're also going to provide our customers and our employees with tokens that they can accrue, based on their health. And, the tokens will get them something, either a drawing in a raffle or some other sort of benefit. And, as they accrue tokens over the years, they might be able to, you know, eligible for a higher level of prize.

And, I think, again, in order to provide a motivation for not only our employees, but our customers, to actually go through and do the health risk assessments, print the results, share it with their PCP,

understand where they could, you know, help improve their own health. So that, in the long term, they're more engaged as consumers, more engaged as patients, and they're able -- we're able to deflect trend moving forward. Because, again, I hate to be repetitive, but the longest term way to improve cost is to improve the health of your employees.

And, so, we're very excited about it. We're rolling it out in 2014 for our customers, in stages using this gamification technology, and radically changing the way that we're assessing the health risk for our customers.

MS. GUERTIN: So, Jeanne, I think you said it in the way I think about it. And that is, I really think the power of an organization like CHI comes with, to figure out how to work above the "competitive fray", as you put it. And, we've talked about this. I think, when you think about the fact that we are -- we are competing on our value propositions, and part of that is how we implement these things. I think the opportunity is always to use that group that you run as a laboratory. So, the pilots, for example, on Medical Home and the like, were really powerful, because we were all participating, and then we all had to go back and say "now, what do we do

with this to bring this benefit to our customers in our own unique ways?"

So, I think, in general, continuing to "pilot" new ideas is really important. I think getting maximum utility out of what we already have developed, so, the all -- I always forget if it's "all-claims payer database" or "all-payer claims database", but either way, utility out of those things, and really leveraging what has been worked so hard to create.

I think Steve brought up something that's really out there to be solved, and that's working together on quality measures we can all agree with, and think are appropriate and applicable, I think, would be a great opportunity for the group. I think, relating it back to something, you know, going on in other business, we've been working with something, and you may be familiar with the concept of "Blue Zones", and this idea that communities or states can really find ways to improve health across the board by engaging, not just the purchasers, the businesses, but all kinds of different stakeholders. And, I think those sorts of things are perfect for such a multi-stakeholder group, which kind of gets back to that idea of "how do we just fundamentally improve health here, while we focus on quality and cost

initiatives as well?" So, I do think those are the next opportunities that are before CHI.

MR. LOPATKA: Actually, I've got a perspective, too, on this. For -- And, wellness and health is -- actually, let me take a step back. Fantastic question, about "what is the next thing to focus on?" And, there's so many difficult issues, and the one that I'm going to bring up now is very difficult, but it's a contributor of both to satisfaction and to costs, which is end-of-life care. So, it's the last -- there's studies out the last six months, contribute 50 percent of medical costs. And, there's also studies that are the satisfaction with that care from -- in the patients before they're gone, and the family members, is not very high. Where that could have been -- can be improved, and it's right care/right place/right time, it's, do you know what I mean, the hot topic that it is, and so controversial and so sensitive. But you can do all the wellness and all the health initiatives that you want, there will be end of life, and there will be a cost associated with that, and there will be an expectation for high quality, where it's palliative and humane, and done the right way.

MR. NGUYEN: I think engagement in technology is one of the areas that's critical.

Technology are moving so fast nowadays, that I think we need to somehow integrate the technology into health care. For example, there are some devices today that you have, you can wear on your hand when you run, it can measure --

(Court reporter interruption.)

MR. NGUYEN: Like devices out there, I think all the athletes nowaday, when they do testing, they have those devices that measure their pulse and heart rates and all that. So, we need to have the consumer engage, and then, at the same time, use technology and help us to reduce the cost of care.

CMSR. SEVIGNY: Any other comments?

(No verbal response)

CMSR. SEVIGNY: Okay. Thank you. Next is the Honorable Chris Muns, a State Representative representing Rockingham County District 21.

REP. MUNS: Thank you, Mr. Commissioner. Yes. I'm a State Representative. I represent the Town of Hampton. This is my first time attending this meeting. So, hopefully, the comments I make will add something to the dialogue.

I've spent the better part of the last three decades managing health plans for large employers. So, a fair warning, I bring that perspective to the

discussion. But I think that also highlights something that I don't think a lot of the public fully understands, and it may be the reason, Mr. Commissioner, you're getting so many phone calls from people. And, that is that a large percentage of the population receives their health care through self-employed plans that the Insurance Department doesn't regulate. And, I think that's just an important thing to remember.

There's another point that I learned over the years that I've been involved with managing health care. And, way back when, when I was in college, I actually got a degree in Economics. And, the health care marketplaces probably violates every rule in economics possible. The providers are in the unique position of not only controlling the supply, but they control the demand. The people that actually consume the product are still very reluctant to ask the same kind of questions that they would when they're purchasing something that can amount to tens of thousands of dollars, as they would be if they were buying an automobile, because, quite frankly, they don't know they're afraid, and, lastly, health care is a very emotional topic. That, you know, and I think that's important to keep that in mind as we talk about what the solutions are.

You know, from a public policy point of view, an efficient health care delivery system is not only important to the health and welfare of our population, but it's also important to the economic wellbeing of the state. The health care delivery system is a major employer in our state. Healthy and productive workers, who are free of concerns about themselves, their families, that's good for business, it makes them more productive. So, it's a very important issue that we need to focus on.

Costs have been and, you know, continue to be a big problem. But the one thing that I'm convinced of is we can't solve the problem by simply shifting costs from one entity to another entity. And, you know, I take -- I claim, you know, guilty as charged, in the sense that some of the health plans that I was responsible for designing, really, what we did, we just moved the costs from the employer to the consumer -- to the employees. You know, but we can't continue to do that. And, at some point, and I'm not sure we're there yet, but at some point very soon we're going to reach a breaking point, where it's just not going to work anymore.

I'm also a firm believer in what I refer to as the "balloon theory", that health care is like a giant balloon. If you press in one place to try to solve

one problem, another problem pops up on the other side of the balloon. And, the key to solving the problem or addressing the problem, in my view, is we've got to get our hands completely around the balloon, and maybe untie the knot a little bit, and slowly push on the balloon and release some of the air in the balloon and try to get the costs down that way. And, that needs a real holistic approach. I think, you know, it starts by getting as many people in the system as possible, getting as many people in the balloon as possible, so that, you know, we give them access to primary care can effectively control their costs.

Wellness is certainly important, I won't -- I won't deny that. But I'll tell you, the one challenge that I had, when I was working on the employer side, was those programs require an investment by the employer. And, it's a -- it can be a large sum of money. And, it becomes a difficult choice for an employer, because the payback period on those programs is fairly long. And, if you're looking at a workforce that's turning over on a fairly regular basis, you basically are making an investment that your competitor or another employer is going to get the payback for.

So, asking employers to invest in that,

really, you know, is -- it may be a little unrealistic. And, so, we may have to have a much more holistic approach, and something that, you know, is -- that everybody is buying into.

I guess some thoughts, reactions, questions, if you will, from the report. You know, I think a couple things that, you know, we need to look at. The Certificate of Needs process, that has always seemed to me that that's something we need to take a look at. I've always wondered why it is that every hospital has to have a, you know, state-of-the-art MRI system, why it is that two hospitals, within 20 miles of each other, both need to be able to do heart transplants. It just doesn't seem to be a very efficient use of resources. So, I think that's something that should be looked at, and I know the report pointed that out.

I was interested in seeing that there were some that suggested that carrier, and I think it was also touched on about hospital administrative costs need to be looked at. Wasn't clear exactly how that was proposed to be done, and whether, in fact, those that were subjecting it were looking for the Legislature to do something.

I think another important thing that we

need to look at is the distribution of doctors by specialty type. I wonder whether, you know, we have the right mix of providers. I think there was some information in the report about the fact that we may not have as many primary care physicians as we should have in certain areas of the state. And, I think one of the things that we have to be very careful about as we look at cost is are we creating -- do we have things in place right now that are encouraging people to go into a certain specialty that maybe we don't really need more of those? I think it's a question that needs to be looked at.

Exclusivity arrangements I notice was highlighted as well, and it was brought out specifically from the point of view of the -- I think the federal benefit program. But I know, in some other work that I'm doing in the Legislature, we're seeing the same issue at the state and the local level. Where certain carriers have locked up exclusive arrangements with certain, you know, municipal organizations. And, you know, I think that that's something we need to look at.

But it does beg the question that, you know, "is competition helpful to the state or is it going to be detrimental to the state?" And, my gut reaction, in most cases, is that competition always helps. But, when

you're looking particularly in some of the markets that we're looking at, Individual Group, and maybe Small Group, where it's a small segment of the population, is it really feasible? So, I mean, I'd be interested in hearing what everybody has to say on that.

The other thing that I found, that I didn't see in the report, that I'm wondering whether it needs to be part of the holistic approach, is how much, you know, the involvement of the community health centers, as a primary vehicle, for particularly delivering primary care, you know, how can that be integrated?

And, then, lastly, I think the -- you know, the other question that all of this raises is, particularly where we are in the country, is do we really need to start thinking about more regional solutions, you know, both instate, but across state lines? And, I know that's something that's outside the purview of the Insurance Department. But, you know, from a health policy point of view, it seems like that may be something that we need to take a look at, to take advantage of synergies that exist across the borders.

So, hopefully, that helps. You know, you're going to hear from Representative Schlachman in a minute, and we both serve on the Commerce Committee,

which, obviously, has some responsibility for what the Insurance Department does. So, if we can be of any help, let us know.

CMSR. SEVIGNY: Good. Thank you, Chris. And, if someone would take a couple of the questions that Representative Muns asked and see if you can give a little -- maybe the one about competition, primarily, is -- let's give an opinion about.

MR. NGUYEN: I guess there's always a balance between competition and efficiencies. For example, in New Hampshire, we have a small population. Just imagine that you have ten carriers competing for small groups, and each one of them had 10,000 members. So, you need efficiency in order to lower your admin. costs. However, at the same time, you want competition, so, no one out there, don't want monopolies and can set the price whatever they want. So, I think you need to have competition. However, at the same time, you need to have the membership base, in order to have cost, I guess, efficiencies in there so you can operate.

MR. GILLESPIE: I mean, I would agree. I mean, we strongly favor competition among products. And, we think that variety and choice for employers or individuals, in terms of plans, plan design, insured,

self-funded, we all think that they all have a valuable role to play in the marketplace. And, you know, firmly believe that competition is the best way to sort some of these --

(Court reporter interruption.)

MR. GILLISPIE: I'm sorry. We firmly believe in competition, is the best way to serve some of these -- sort some of these issues out. I'm sorry.

CMSR. SEVIGNY: Okay. Good. Thank you. Then, let me follow -- let me follow up a little bit on that. Competition can be viewed as something that is the answer to everything. It can also be viewed as something that is difficult to reach. And, if I heard you correctly, Tu, in a population like New Hampshire, it may not be realistic to think that you could have ten carriers that would put an investment into accreditation, put an investment into network development, put an investment into marketing, and put an investment into all of the things that need to be invested in in order to be a viable player. And, I think that that's not always clearly understood. There are those that say, you know, "go out of state to get your competition." Well, where's your network going to come from?

So, I mean, I'm just thinking, you know,

I'm glad you pointed it out, is what I'm saying. Any other comments?

(No verbal response)

CMSR. SEVIGNY: Okay. Good. Next, we're going to hear from the Honorable Neal Kurk, a State Representative, representing Hillsborough County District 2. Neal.

REP. KURK: Thank you, Commissioner. As a State Representative for most of my career, as you know, I've been on the Finance Committee. So, I've urged our state to budget much, much less for Medicaid reimbursement, and I'm part of your problem. We probably have reached down about as far as we can go. I don't think we want to go too much below 50 or 55 percent. And, we read the reports that Mr. Norton puts out explaining how we're cost-shifting. So, we're aware of what we're doing. But, when you balance the equities, it's a rational decision.

Like me make one comment first about the CON Board, and then I'd like to talk about the -- or, ask questions about my primary issue, which, as you might expect, would be costs. In this year's budget, we revamped significantly the CON Board. The revisions, I believe, take place in January 1st of 2014. We've changed

the structure of the Board itself, so, the fox is longer guarding the chickens. And, we've changed the standard by which the Board is going to reach its decisions, to make it much broader. In other words, it's not simply a standard of whether a particular provider can provide a service at a lower cost. It's a question of the total impact of those costs to the state, as an entity, and also to the individuals in the state.

We based a lot of the work on Elliott Fisher's recommendations. He and his colleagues in Dartmouth think that, in the next five to ten years, there will be a lot more price information availability. And, many of us in the Legislature hope that, when that day comes, the CON Board can disappear. But, perhaps that's a bit overoptimistic.

Now, on costs. The thing that I was a little disappointed in in the report, although it wasn't the function of the report, was the fact that the insurance industry, and health care, in particular, does not really harness the cost-cutting shopping power of the very knowledgeable American consumer.

With respect to the Department, Commissioner, I would hope that you would look seriously into bringing antitrust lawsuits against a number of the

hospitals and other providers through the Attorney General's Office. Some of them have brought up practices and, in effect, are monopolies. And, that's one of the reasons why we have high health care costs. So, there's something for the Department to do, I believe, in this area.

As far as provider costs are concerned, if we want to bring down costs in ways beyond those that have been mentioned, we need to give the consumer a strong financial incentive. So, for example, if I choose the lower-cost provider, and my insurer will tell me that I have a choice of three people for the mammogram or the colonoscopy, or whatever the service is, and will tell me what the cost is and how much will be saved if I choose that cost, against perhaps its average cost or some other measure, give the consumer 50 percent, in cash, form of check, perhaps, as a maximum, equal to his deductible, perhaps the maximum is equal to the cost of the policy, but provide some sort of real incentive. And, I can assure you that we will shop and we will choose and we will make the value judgments, as to whether or not, going an extra 30 miles or seeing a specialist who's been highly recommended is really worth the extra costs.

We've tried this, to some extent, in the

state health plan, at such a modest level, that I don't think it's an incentive. I think it's $25 or $100, some paltry amount.

Tiering is an interesting concept. I don't think it goes far enough, but it's a small step in the right direction.

As far as giving us price information, I've said that the insurers can do that, especially, if, in a particular plan, my savings, as a percentage of something, would be your obligation to provide that. The Department has gone a way in its website to provide information. But, because of the fee-for-service model, it's very difficult to figure out what anything costs.

With respect to -- and, providers, of course, can provide more information, but they really don't know what their costs are. And, if they got cost accountants in there, it would change the nature of health care in the state. A lot of charges are unrelated to costs, but are related to profit.

And, finally, as far as drugs go, why not give us an incentive to shop around and use the Internet? Why do we always have to use shop-by-mail or the local pharmacy. A lot of us buy our drugs on the Internet, because we pay for them ourselves and save

substantial amounts of money. So, if that is a policy that your company is offering, why not give us an incentive to use the lowest-cost provider, which often is on the Internet.

So, my question is, how about some real action on the part of introducing price competition into the provider choice, and give the consumer significant financial reward to make that work? Thank you.

CMSR. SEVIGNY: Thank you, Representative Kurk. Lisa is nodding her head. So, she can take a shot at this.

MS. GUERTIN: Sure. Well, -- there you go again. I think you're raising a great point, and I think we're getting there. I will tell you that, while it may not be 50 percent incentive of the difference, if you look at sort of the range of incentives, cash incentives that are out there for being a price-sensitive shopper on our plans, it goes up to a $500 check coming in the mail.

REP. KURK: Not 5,000?

MS. GUERTIN: Not 5,000. But this is for a single infused drug treatment, REMICADE. And the price difference --

(Court reporter interruption.)

MS. GUERTIN: REMICADE. It's an infused

specialty drug. And, the price difference is so big, depending on where you go, that we can send a member a check for $500, and still return a lot of savings to the premium cost or to the self-funded employer. So, I don't know that we're all the way there, but we're getting there, to try to make sure that we really have meaningful incentives for consumers. I've heard in the national account space, one of the most popular benefit designs for the coming year, in other parts of the country, is reference-based benefits, and that's for certain services. There's a bell curve of costs identified. And, the employer says "Your benefit is going to pay enough for you to go to 75 percent of the places on this bell curve. And, you can go to the others, but you will pay 100 percent of the cost yourself."

So, I will tell you, I think that, generally, what you're talking about is becoming more commonplace, and that is large incentives, trying to break through to the consumer and say "No, this is real. And, you can participate in these savings, if you pay attention." So, I think you're right, and I think it's beginning to take hold.

CMSR. SEVIGNY: Thank you, Lisa. Does anyone else want to? Pat.

MR. GILLESPIE: Just to say, just to echo what Lisa had said. And, I think, when you see the high deductible health plans and trying to impart that kind of an economic incentive, you know, in a lot of respects, we're going to respond to what employers are telling us they want, what their employees want. And, we're selling to them. We make those products available. And, I think, regionally, you see a lot of it in the south and in the west, you see high deductible consumer-directed plan, no first dollar benefit. But it does represent sort of a culture change among employees and among employers to go in that direction. But we have, obviously, we have those products available, and, you know, we're responding to the employer demand and to the marketplace.

MR. NGUYEN: The new product design that we have actually emphasize that point. I guess we can argue the case of how much incentive, but I think we are definitely heading there.

CMSR. SEVIGNY: Good. Thank you. Next, we're going to have hear from the Honorable Donna Schlachman, State Representative, Rockingham County District 18. Donna.

REP. SCHLACHMAN: Thank you. District 18 is the wonderful Town of Exeter. Commissioner, thank

you for having us. I'm going to keep my remarks focused on the consumer side of the insurance market with regard to health plans offered in this state. And, because I believe that, in spite of all the discussion today about product innovation, we are very anemic in this state with regard to responding to those who access Complementary and Alternative Medicine services, such as acupuncture, nutrition, --

(Court reporter interruption.)

REP. SCHLACHMAN: -- naturopath. There is a segment of our population that are successfully cared by these, and other health care providers, who are ill-served by our insurance marketplace. And, these consumers are continually denied coverage for preventative and wellness services and chronic disease management that they use, even with the implementation of the essential benefits -- health benefits under the Affordable Care Act in this state.

Except for the recent expansion of naturopath coverage, and I applaud Cigna and Harvard Pilgrim, actually, in their response to this. The CAM, the Complementary and Alternative Medicine products, have been left out of the insurance market.

And, I'm going to give you an example of

how this feels, just bear with me. It's an old story, but I don't think anything has changed today. In 1999, at the age of 50, I was diagnosed with breast cancer. And, after I had surgery in Boston, which I went there because I was able to access a considerably less invasive and extensive surgery, after that, I worked with a New Hampshire MD, who had an unconventional approach to cancer treatment. And, under her guidance, I avoided the standard post-surgical radiation, and its long and short term side effects, and five years of the drug tamoxefin, which was prescribed for treatment at that time. But, in not accepting the insurance-covered radiation and prescription drug protocol, I had pay out of pocket for my twice weekly self-injected prescription drug. I had to pay out of pocket for the Ph.D nutritionist that I worked very closely with, and had to pay out of pocket for the Master's level acupuncturist, who were all part of the medical treatment plan that my doctor designed. In other words, aside from the surgery, my very successful treatment was not covered by health insurance. While at the same time I saved my insurance company the cost of ten weeks of radiation and five years of this drug, none of this out-of-pocket expense was applied to the deductible for my health insurance product.

And, I don't feel this is an uncommon story. Even when medical doctors refer their patient for CAM evidence-based medical services, coverage is not available. And, this is not necessarily because carriers believe the service to be unproven or ineffective. I learned a few years ago, in a hearing in the House Congress, that, if I go to a medical doctor who took a course in where to insert acupuncture needles, that would be covered under my plan. But, if I go to a certified acupuncturist licensed by the state, treating the same ailment, who has three to four years of graduate level Chinese Medicine training, that person is not eligible for reimbursement.

So, New Hampshire consumers who use these medical practices or health practices, whether in collaboration or in replacement for medicine that isn't insured for their preventative and wellness care, with few exceptions, they are excluded. And, for some consumers, what they're doing is successful, and it's fundamental to their wellness or their disease management.

And, so, I just feel very strongly that, and I have two questions at the end, and you can guess what one of them is, I don't think it's right that consumers are basically subsidizing some of the products,

and they're certainly being left out.

And, it's a small part of our health care system, we know that. You can read the report. It's, you know, at best, right now, maybe 6.3 percent of our population is accessing this health care. But there's also an indication, and you can read these, too, because I've heard this argument, "we can't" -- "we can't do it, because people will use both. They will be doubling the amount of health care we're paying for." But, in fact, this is not shown to play out in states that are doing this. And, rather, there's evidence that the costs to the system even or out, or are less costly. There's less risk -- risky care replacing the insurance-covered expensive and less effective forms of treatment in some cases, care that sometimes carries long-term side effects.

And, the people, my sense, is that many of us who seek our health care in both systems don't need tokens, we don't need prizes, we don't need returns in order to motivate us to make wise decisions about our health care.

So, the report recommends an increased investment in primary care. And, I think a lot of the providers in this Alternative/Complementary world are primary providers. So, what I want to know is if any of

you are developing products that people like me would actually be interested in being insured under? And, so, that's -- because I know that some of the successful things we've done in this state around ACOs and Medical Homes, are really around the traditional medical model of nurse practitioners and physicians. I've gone online and I've read the staff in every single ACO that we have. And, I don't see anyone that I would want to go to for my primary care. And, so, that's one question.

And, my question to the Insurance Department, related on the same thing, is what can you do to review and evaluate consumer payment issues to determine whether or not to intervene in the market, that is taking in a lot of money for health care that never gets applied to any deductible? So, thank you.

CMSR. SEVIGNY: Good. Thank you, Donna. And, let me ask our panel of carriers if they have any response to Donna's question?

MS. GUERTIN: Hi. And, thank you. Well, we know this is an area of huge interest for you, and we've had some conversations. So, I'll point out a couple of things. One is that, for -- we're the only carrier here who does have the individual market as well, and it is covered there. So, the real -- yes, it is. But

the gap is on the group side, where we hadn't made a determination on that yet. And, we did have some very specific things we were trying to work through. Not to be stubborn, but because, with any of these considerations, the balance of trying to meet a need and to help people get to the right care, with potentially some good news, but also potentially some new sources of costs, is just something we've been a little bit, frankly, cautious about.

So, for example, the question of admitting privileges came up for us, and what would happen if these folks needed to go in the hospital and NCQA. These are things you know we've talked about. We are still in consideration for 2014.

REP. SCHLACHMAN: You're just talking about the naturopath piece of it?

MS. GUERTIN: I am. Yes. And, I know it's a bigger thing. But it's not a closed topic for us at all. We will continue to talk with you and to look at it, and to try to figure out what's best. And, we definitely do understand your perspective and your concerns.

CMSR. SEVIGNY: Anyone else? Yes, Pat.

MR. GILLESPIE: Just as part of the

challenge for Cigna, as a national carrier in all 50 states, there are state licensing differences within each state. And, we've had, as legislators, you've seen turf fights among licensees for this kind of treatment or that kind of treatment, who licensed to do what.

So, part of the challenge in designing alternative products, as the Representative had mentioned, at least for us, is that we have 50 different states we're operating in, and to try and harmonize it or, you know, some of these different licensing procedures. Because I know naturopaths, for example, are not licensed or recognized in each state. And, we're somewhat at the mercy of state licensing boards in that regard as well, and state legislatures, too.

CMSR. SEVIGNY: Thanks, Pat. As far as your question for the Department, maybe Tyler can ask a question that will help answer it.

MR BRANNEN: Yeah. I mean, to some extent, we have access to the claims data. We certainly don't collect data on benefits that are covered. So, we wouldn't know what was being paid. But I guess a question for those who have an actuarial background up here, would you think, if you were enrolling populations that were insured and using these types of benefits, would you be

attracting a healthier population on average or one that potentially is an adverse selection?

MR. GILLESPIE: It's a good question, Tyler. And, I think, you know, Cigna, and I assume all my colleagues, we take patient safety seriously in terms of protecting our patients. And, one of the reasons why maybe there's such a conservative approach about new treatments or experimental treatments, is because we do try and place that value. And, it's a good question, and I don't know if I'd have the answer for you right now. But we do see, in some states where they have coverage mandates for certain types of treatments, a concern about increased morbidity and increased risk for some of the mandated coverages.

For example, at-home births, our market medical effects are concerned, where at-home births are required, that there's an increased risk, and there's, you know, an increased risk to the patient. And, we've seen that in various markets. But, you know, again, we're required, with the state mandates that we cover it, that we cover it. But -- so, I think it would probably be a lot of research for use to make a determination on that point.

MR. NGUYEN: Keep in mind that, under --

(Court reporter interruption.)

MR. NGUYEN: Keep in mind that, under health care reform, we do have the risk assessments out there. So, the questions that you asked about "is carriers worried about that they are attracting high risk and all that?" I think that's no longer applicable. So, I think the key here is, is these alternative medicines effective? And, I think carriers probably review some of these alternative medicines. And, if it is effective, I think they were very open to considering offering discounted benefits.

CMSR. SEVIGNY: And, for the Department, as Tyler started to say, it's not -- it's not anything we can assess or evaluate, because we don't collect the data. And, without the data, we really don't have anything to report on. So, any other comments?

(No verbal response)

CMSR. SEVIGNY: Okay. We've got a couple of other folks that have asked to speak. Charlie White, from the northern sector of the State of New Hampshire. Charles, if you could address us please.

MR. WHITE: Thank you, Commissioner. My name is Charles White. I am the Chief Administrative Officer of Upper Connecticut Valley Hospital, in

Colebrook, New Hampshire. And, I think it's really important to bring the voice of rural citizens to this hearing. We've spent a lot of time talking about costs, but we haven't spent a lot of time speaking to access to care.

So, Upper Connecticut Valley Hospital is the smallest critical access hospital in the State of New Hampshire. We serve over 850 square miles. We are the most geographically isolated and rural part of New Hampshire. And, we have very limited access to transportation, public transportation. And, obviously, I'm a little bit nervous, because this is my first testimony before you folks.

The citizens we serve have the poorest health outcomes in the state. And, they have the most medically underserved needs in the state, as demonstrated by the public health reports. Imagine living in Pittsburg, New Hampshire and being told that the closest place to get an x-ray or physical therapy is an hour and 15 minutes away from your home, one way, in good weather. Now, imagine trying to make that drive in the winter.

Imagine coming to the Upper Connecticut Valley Hospital emergency room with pneumonia, and being told that you need to be transported by ambulance to

another hospital, because your insurance will not cover an inpatient hospitalization at your local hospital. Imagine being told that the local ambulance service does not have a contract with your insurance carrier, and that now you are responsible for the out-of-pocket expense for that ambulance transfer.

Imagine being told that you require chemotherapy, but your insurance will not pay for it, because they did not contract with your local hospital. Imagine deciding to defer treatment, because you do not have transportation to the next closest hospital. Imagine that this is January 1st of 2014, and that this now is your reality.

Strategies to develop limited networks appear to penalize rural citizens by requiring additional out-of-pocket expense, specifically, travel expense and loss of work time. How is the Department of Insurance prepared to protect the interests of rural consumers in regard to access of care to narrow networks and the inherent additional costs associated beyond premium rates. Specifically, there's an economic penalty for rural consumers, who pay the same premium rates as urban consumers who may have additional choices.

CMSR. SEVIGNY: Great. Thank you,

Charles. What I talked about earlier was the fact that our responsibility is to regulate according to the law. And, if the law were to change, then we would change how we regulate. But, in today's environment, and the way the law is written, we've determined that the network adequacy rules have not been violated, therefore, there is nothing we can do to -- we have nothing to enforce, I guess is what I'm saying, because there have been no violations.

Does that mean we ignore it? No. As a matter of fact, the carriers will all tell you that we interact with them on a regular basis, on a whole host of issues, not the least of which is our issues like point-of-service or network adequacy, we do. We will continue to. But, at the same time, if the law stays as it's written, there is nothing to enforce.

Next is Representative Michael Cahill. I think Michael -- yes, he is.

REP. CAHILL: Good afternoon, Commissioner, and panel. I'm here today largely because of the narrow network. And, I think you're making my work easier in my quest for a universal single payer. The arrogance of this take-it-or-leave-it approach you've taken with the Commission, with the employers, with the subscribers. This is -- subscribers are a group that

we're not hearing from as stakeholders. But they're the ones who are paying the price, they're the ones who aren't getting care who -- employers who can't afford these premiums and these deductibles that they are passing on. And, they're the ones who are being laid off as a cost of -- unbearable cost of business because of the greed of the insurance companies.

Anecdotally, I mean, I've had insurance in the past. And, I was offered a chance to save some money by going to an urgent care center. But, unfortunately, there was not one in the network in anywhere near where I lived. I've been -- I've been through things with, you have a colonoscopy, you are covered, if it's routine. But, if they find a polyp, and they're supposed to remove it, well, now, it's not covered. The insurance company is a disaster.

So, what we really need is a more sensible, European-style, yes, I know it's controversial and socialism, but it works. Our system has failed, it's failing us. And, I sympathize with the Commission, because they have no authority to do any better than they had with the take-it-or-leave-it approach from Anthem and the rest.

Another quest I'm on, unrelated to this

issue, is the metascan, which is a terrible burden on our hospitals. And, we use it to pay our bills. We use it to fund the General Fund. It's unfair, it's dishonest, and I'd like to see it stopped. Thank you.

CMSR. SEVIGNY: Thank you. The last speaker that we have listed on our list here couldn't stay, but asked that a statement be read into the record. And, Tyler, if you could do that for us please.

MR. BRANNEN: "Dear members of the New Hampshire Insurance Department: I am writing to you as a individual purchaser of health insurance in New Hampshire who will be significantly adversely affected by the impact of the Affordable Care Act. My wife and I have purchased our own policy from Anthem since 2010, but since we changed our deductible, in response to a 40 percent increase in premiums for the 2011 plan year, we are not grandfathered and our current plan will no longer be offered.

In the last month we have learned one troubling piece of news after another about the new insurance options we will have. As Hopkinton residents, we were dismayed to learn that Concord Hospital, the only local option for us, will not be a part of Anthem's new "Pathway Network". While the Affordable Care Act was sold

to the American public under the auspices of "You can keep your doctor, you can keep your plan", we're quickly finding out that we will be able to keep neither our doctor nor our plan. **[**As**]** I am sure you're aware, continuity of care is important from a parent perspective, having to find new doctors is disruptive and affects the quality of care.

To make matters worse, it seems, from the preliminary plan information I have seen (Anthem flyer: Anthem and the Individual Marketplace), that we will be faced with both higher out-of-pocket maximums and higher premiums.

Decreased access to doctors and hospitals, combined with higher monthly premiums and higher out-of-pocket maximums combine to make the Affordable Care Act a triple-whammy for my wife and me. We are looking at a lose-lose-lose situation.

Anthem New Hampshire President Lisa Guertin has noted", and there's a reference to a Concord Monitor article, **[***http://www.concordmonitor.com/news/work/business/8491779-95/anthem-takes-heat-from-nh-senators-over-limited-provider-network-for-marketplace-plans***]** "that "More than 90 percent of our potential customers will be within 20 miles of a short-term general

hospital", and also "The provider network for about 90 percent of Anthem customers will remain the same, the company said."

I am in the losing end of 10 percent on both of those segments. I will no longer live within 20 miles of an Anthem in-network hospital, and my provider network will not remain the same.

I would hope that since the number of consumers stuck in this boat with me is so small, according to Anthem's own claims, that Anthem would be able to find a way to continue to offer us the choice of provider coverage that we currently have, so that we can avoid the disruption of changing doctors and suffer the disruption of care which results from such changes.

Higher monthly premiums and higher out-of-pocket maximums are undesirable, of course, but, when combined with the decreased access to care, how can one feel anything but anger toward the impacts of the Affordable Care Act?

Thank you for your time. Josh Kattef, Hopkinton, New Hampshire."

CMSR. SEVIGNY: Thank you, Tyler. This hearing has gone about 50 minutes longer than was planned, but the good news is, we did book this room up until 2:00.

So, if there's anyone else that has additional comments they would like to make, either from the audience, or Martha has got someone on the Webcast that she's been --

MS. McCLOUD: I do. And, if I can read this, it's from --

(Court reporter interruption.)

CMSR. SEVIGNY: We had 29 people on the Webcast, by the way.

MS. McCLOUD: Actually, we were up to 33 at one point, so even more.

"Has anyone considered how the effects of improper medical coding, which is a huge issue, as to the impact of consumers and having to try to keep -- to keep up, if it's even legitimate billing for the actual procedures?"

So, I don't know if that's -- how that question relates to anyone.

CMSR. SEVIGNY: Pat.

MR. GILLISPIE: Yes. And, I'm not sure if this person comes to it from a particular perspective. But one coding issue that we found nationwide, not just in New Hampshire, but across the country, particularly is for ABA services, for patients with autism or with Asperger's. And, there is no uniform coding standard that carriers

have. And, there's been lots of back-and-forth. And, I think it's the source of a lot of the problems that parents with children who have autism face, in terms of interacting with insurance companies.

And, you know, Massachusetts, New Jersey, we've had lots of conversations with insurance departments. But, again, it really cries out for a national solution to have a uniform set of CPT codes that are applicable to ABA therapy.

So, I understand the -- certainly understand the concern that, in this one particular instance that the questioner had raised. And, as if we didn't have enough things going on in the insurance marketplace, we have ICD-10 coming, which will be a substantial transition moving forward, that providers of facilities are going to have to implement, as well as carriers. And, we've tried to get ahead of that curve, and have implementation plans out there. We're rolling out surveys to all of our facility and provider partners, to understand where they are on the ICD-10 implementation stage. But, again, given just ACA, ICD-10, which there's lots of things going on in the marketplace, and, hopefully, it won't be too disruptive.

CMSR. SEVIGNY: Thank you. And, Lisa, I

know you had some comments that you wanted to make as well, in responding to --

MS. GUERTIN: He just left.

CMSR. SEVIGNY: -- someone that just spoke a minute ago.

MS. GUERTIN: He's left. And, I'll still make them, although I was intending to reply to him. And, what I would say, I guess trying to keep this concise, I think, if there's one thing we've all heard today is that there are no easy answers in health care. And, I'm certainly not going to go all the way to defending a private system versus a socialized or single payer system. I think that's outside of the scope of this dialogue.

But I will say that, in general, we know that there are no easy answers. And, as we go into 2014, with an emphasis on trying to make sure that people who haven't previously had coverage have an opportunity to gain that coverage.

Very simply, all we did is try to balance access and affordability. I fully acknowledge that rural health care in New Hampshire is a challenge, with or without the ACA, with or without the narrow network. It's interesting that, in some of the UMass.

information, we actually heard some people in the south saying they're already subsidizing, yet you sort of can't please everybody. Because, on one hand, the people in the south are complaining about costs, and subsidizing those costs in the North Country. We could have multiple geography rating factors; we don't. This is a very complex issue. And, without a doubt, even within the statutory guidelines for access, the driving distances are farther in the north, we recognize that.

I think, for me, we heard that the high risk pools at the state and federal level have medical loss ratios that are astronomical. So, even on our State-run pool, for every dollar of premium they collect, they're paying out $1.60 in claims. For the Federal pool, for every dollar they collect, they are paying out $9.00 in claims. Those are the people coming into the individual market rating pool next year, as well as the uninsured. If something didn't give, then, every customer would have been faced with a premium 30 or more percent greater than they will. This is a trade-off. And, it isn't perfect for everyone by any stretch of the imagination. But, I fully believe, if we didn't make that move, then, we'd be hearing concerns of a different kind affecting even more consumers.

So, we don't in any way minimize the challenges of rural health care, the importance of the physician/patient relationship. We'll do everything we can to minimize that disruption, be it transitional care, coverage for emergency room, coverage for ambulance transport at in-network levels.

But, if you look at what the Department of Health & Human Services released yesterday, and if you believe it, they showed the expected premium rates for Exchange plans in the 36 states that will use a Federal Exchange. And, instead of being second highest in the country, like we're used to, the worst position we had was being the 10th highest. And, for some purchasers, we will be in the middle of the pack -- better than in the middle of the pack, 23rd highest. That is a really important breakthrough for insurance purchasers in the state. And, it's not that there aren't some that are disproportionately affected, we are not trying to discriminate. We're trying to help as many people afford this as we can, within some defined parameters, that, ultimately, I guess the state needs to decide if they're the right parameters, but that's what we used.

And, I will say that, if we're not willing -- if we continue to say "New Hampshire is

different because", "because", then we won't ever move the needle. And, it's not a take-it-or-leave-it attitude, and it's certainly not insurance company greed. Because we'll be -- if we make too much money on this, we'll be giving it right back in rebates.

So, it's a complex issue. There are no easy answers. It's not perfect. But I do believe that many people will be able to benefit from insurance coverage, and I hope that helps all hospitals and all consumers in the state.

And, I will use some other forums to address this more fully. It really wasn't the focus of today. But we know it's a very, very important topic to people right now. I did want to at least address it a high level, and we will certainly have other opportunities to do that more fully.

CMSR. SEVIGNY: Yes. Thank you very much, Lisa. Certainly, we've heard a lot this morning and this afternoon about the cost of care, the cost of health insurance, where the state ranked, and where it's going to rank. We've heard about efforts that carriers are making to address the cost of care and to try to bring health insurance premiums into a more affordable place. And, we've heard about reactions to these efforts. I think all

of that is worth continuing to consider.

And, I think Lisa made a really good point just now, saying that New Hampshire needs to decide, we, all of us, the Legislature, us working with our Legislature, where we want to be, and what we want to pay, and what we're willing to withstand to pay what we want to pay.

So, I think it was -- I really appreciate everybody's participation. And, special thanks to the panelists for staying up there this entire time. And, for those of you that contributed to this morning and this afternoon's proceeding. Again, thank you very much.

Unless there's anything from anyone else?

(No verbal response)

CMSR. SEVIGNY: I'll bring this hearing to a close. And, you can expect a report that we're going to put forth in the next little while.

(Laughter.)

CMSR. SEVIGNY: Thank you very much, everybody.

(Whereupon the hearing was adjourned at 1:59 p.m.)