

New Hampshire's Health Insurance Market and Provider Payment System: *An Analysis of Stakeholder Views*

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PREPARED FOR

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1. Executive Summary

The New Hampshire Insurance Department (NHID) contracted with the Center for Health Law and Economics at the University of Massachusetts Medical School (UMMS) and its partner Freedman HealthCare, LLC (FHC) to analyze the current health insurance payment system in New Hampshire and factors affecting premium rates and health care costs. The team gathered information through interviews with 26 health care industry stakeholders, including providers, carriers, and consumers. Additionally, the team received data from three large New Hampshire carriers regarding payment methods and plan design. The team supplemented the interviews with an analysis of the 2011 New Hampshire Comprehensive Health Care Information System (NHCHIS), as well as other reports from NHID and nationally published literature on health industry topics.

Stakeholder Viewpoints on Cost

Every stakeholder interviewed expressed concerns about the high cost of health care in New Hampshire.

- Employers were concerned about affording coverage for their staff, and, in particular, were evaluating potential changes to their coverage policies in light of the Affordable Care Act; and
- Stakeholders cited New Hampshire's high deductibles and premiums as a significant issue.

Stakeholders pointed to a number of different issues as drivers of New Hampshire's high costs:

- Some carriers stated that costs are high due to hospital billing methods, such as billing for a facility fee for off-site care and hospital acquisition of physician practices. One carrier suggested that that state should require hospitals to review and reduce administrative costs. Another carrier noted that New Hampshire hospitals have higher margins than hospitals in other states.
 - Many providers felt that low Medicaid payment rates shift costs onto commercial payment rates;
 - A hospital representative cited Anthem's exclusive relationship with the Federal Employee Program as a cost-driver, stating that because Anthem pays higher rates to providers for this group, provider then expect higher payments from other carriers;
- Some stakeholders felt southern residents subsidize higher-cost providers in the north, and multiple interviewees stated that providers in rural regions without competition are able to command higher prices;

What We Can Learn from Data on Costs

Research supports the stakeholders' general perception that New Hampshire residents have high health care costs.

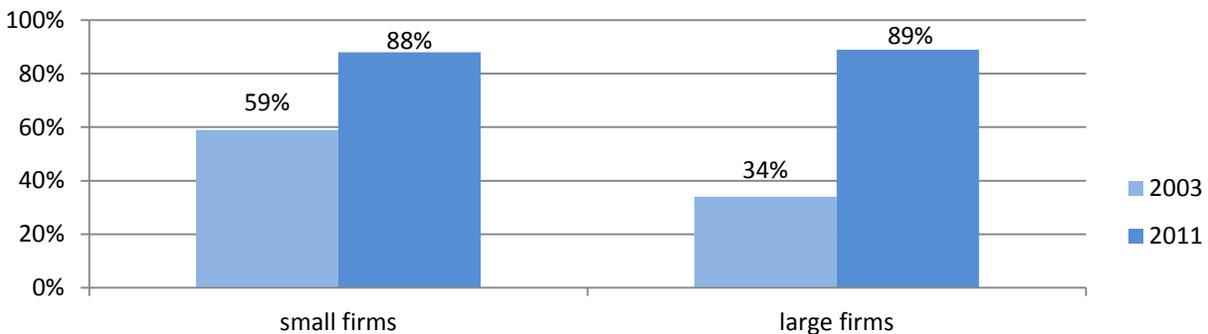
Premiums: A report on 2011 premiums from the Commonwealth Fund shows that New Hampshire's family premium of \$16,902 is the second highest in the country, after Massachusetts premiums.

Deductibles: New Hampshire's average deductible for family plans (\$2,887) is 25% higher than Massachusetts' average deductible of \$2,177 and almost double the lowest deductibles in the United States.¹ The percent of employees with deductibles increased at both small and large firms – see **Figure 1.1**.²

¹ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210.pdf.

² Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011,

Figure 1.1: Percent of employees with a deductible, 2003 vs. 2011



Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*

However, despite an increase in membership in deductible plans, most consumers did not incur a deductible amount during provider visits. The team’s analysis of NHCHIS data indicated that, in 2011, 36% of members had deductibles of \$1,500 or higher,³ but only 1.4% of members actually incurred charges of that amount.⁴

Cost-shifting: Many health industry participants nationally believe that cost-shifting occurs—that providers recoup Medicaid and Medicare losses by seeking higher payments from private carriers. However, a number of studies do not support that premise, such as an April 2013 study which found that a 10% reduction in Medicare payment rates led to a 3% or 8% reduction in private payment rates between 1995 and 2009.⁵

Regional subsidies: The team found little evidence to support the contention that the southern population subsidizes the north. A prior analysis of prices paid to hospitals in the northern, central/western, and southeastern regions found no statistically significant differences between the regions.⁶ While the northern counties have a higher percentage of residents over age 65, the population in the north is too small to have a significant impact on overall state costs.

Stakeholder Viewpoints on Competition

During the interview process, the project team asked stakeholders for their opinions on how competitive the insurance market is. The questions addressed the contracting environment in New Hampshire, how

http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_s_tate_trends_premiums_deductibles_2003_2011_1210.pdf

³ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nh_id_suprpt.pdf.

⁴ Based on authors’ analysis of 2011 NHCHIS.

⁵ Chapin White, Health Affairs, *Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates*, May 2013, <http://content.healthaffairs.org/content/32/5/935.full>.

⁶ Katharine London, et al., University of Massachusetts Medical School, *Analysis of Price Variations in New Hampshire Hospitals*, April 2012, <http://www.nh.gov/insurance/lah/documents/umms.pdf>.

the level of competitiveness has affected costs, and the role of dominant carriers. Key comments on carrier competition included:

- Most providers interviewed said they have not observed competition among insurance companies. However, the carriers themselves felt they are very competitive;
- Anthem Blue Cross Blue Shield was described by several stakeholders as affecting the insurance environment through their push to include site of service⁷ incentives in all Small Group products;
- Interviewees from multiple stakeholder categories mentioned that due to New Hampshire's small population, the addition of new carriers would not improve health care costs or delivery and the risk pool is not large enough to support additional carriers; and
- Most providers interviewed said they feel powerless when it comes to negotiations with health plans.

There is “more competition among providers because patients are starting to shop,” a provider said.

Stakeholders also expressed opinions on competition among providers:

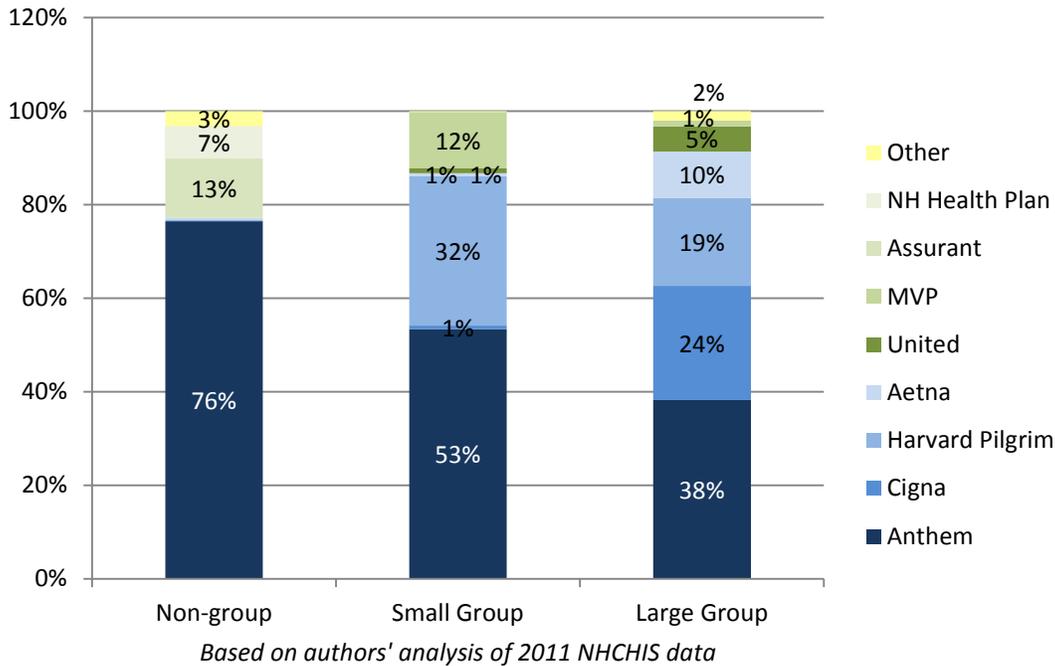
- When asked about hospital competition, interviewees in all stakeholder groups recognized that due to the state's geography, there is little competition among New Hampshire hospitals, except in the cities of Nashua and Manchester;
- Stakeholders felt hospitals are more collaborative than competitive, for example sharing specialists and call coverage in rural areas;
- Some carriers felt that hospital purchases of physician practices reduced competition among providers and gave hospitals more power during contract negotiations; and
- Carriers interviewed agreed there is little competition among physicians, and they find it difficult to negotiate competitive rates among physicians that have developed geographic monopolies.

What We Can Learn from Data on Competition

Figure 1.2 illustrates the market shares for the New Hampshire commercial health insurance market by Group size. Anthem is the largest carrier, with nearly 41% of the state's members, followed by Harvard Pilgrim Health Care (20.4%) Cigna (18.7%), and Aetna (7.8%).

⁷ Site of service refers to reduced cost-sharing when patients use preferred providers, such as independent laboratories and ambulatory service centers not sited at hospitals.

Figure 1.2: Market Share by Group Size



The team completed an analysis of carrier market share using the Herfindahl–Hirschman Index (HHI)⁸, a widely accepted measure of market concentration. This analysis indicated that the Non-group and Small Group markets are not competitive due to market shares being concentrated among a few carriers, while the Large Group market has more moderate concentration.

A similar concentration analysis of three hospital markets with potential competition found only the Nashua-Manchester region has a moderately competitive hospital market, while the Mid-state I93 region and Coastal region have highly concentrated markets. The team did not conduct a concentration analysis of the non-competitive rural areas of the state.

Physician markets vary widely across the state. For example, there is extensive variation in the number of residents per primary care physicians. There are more physicians per capita in Grafton and Coos Counties in the north, while in Hillsborough and Rockingham Counties, the two most populous counties in the state, have half as many physicians per capita as Grafton County.⁹ The team did not conduct a concentration analysis of physician markets.

Stakeholder Viewpoints on Plan Design

The team asked stakeholder to comment on the role of plan design in the New Hampshire market, including tiering, patient cost-sharing, and other benefit options. Some of the key comments received include:

⁸ See **Appendix D** for a description of the methodology and data used in calculation HHI scores

⁹ Robert Wood Johnson Foundation, *County Health Rankings and Roadmaps*, <http://www.countyhealthrankings.org/app/new-hampshire/2013/coos/county/outcomes/overall/snapshot/by-rank> (June 2013).

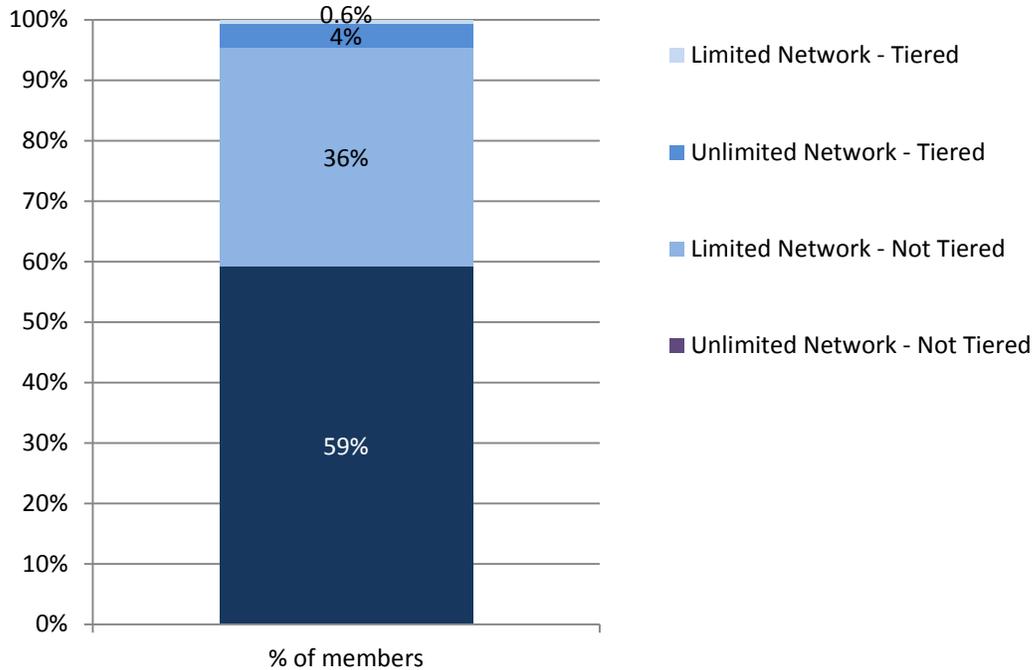
- Employers stated that they found plan design changes to be successful levers for controlling costs. Increases in co-payments and deductibles, as well as use of site of service, have reduced premiums and enabled employers to continue providing coverage for their employees;
- Providers were concerned that site of service fragments care, and hospitals are concerned about the revenue they lose when patients are steered to non-hospital facilities;
- Employers are also increasingly moving to self-funded insurance programs, which they believe gives them greater flexibility and reduces costs better than fully funded programs do;
- Providers have concerns about the impact of the shrinking pool of fully insured members, which may result in premium increases for the smaller, higher-risk pool that will remain in the fully insured market;
- Most stakeholders emphasized the need to focus on primary care to reduce costs. Notably, the employers interviewed have invested in employee wellness programs and on-site medical care, with a goal of reducing insurance costs through lower utilization of services; and
- Most stakeholders, including carriers, were not in favor of provider tiering as a strategy to improve care and reduce costs. Interviewees mentioned that tiering of providers is challenging in parts of New Hampshire where the choice of provider is limited by geography.

What We Can Learn from Data on Plan Design

Consumers are choosing equally between PPOs, which cost more but offer more freedom to select providers, and HMOs, which lower costs through reducing choice of providers. According to the three carriers who responded to the UMMS survey, the majority of their members (59%) are in products with no tiering¹⁰ or network limits, while 36% are in limited networks, also without tiering. See **Figure 1.3**.

¹⁰ Tiering involves carrier assignment of hospitals or physician practices to different tier levels based on a defined set of quality, cost or utilization metrics; patients incur varying levels of cost-sharing based on the tier of the provider from which they receive care.

Figure 1.3: Percent of members by network type, 3 large carriers



Source: Authors' survey of 3 large carriers' 2011 data

Stakeholder Viewpoints on Delivery and Payment System Reform

Another approach to reducing costs and improving quality involves more extensive delivery and payment system reform efforts. The interviewers asked stakeholders to comment on recent initiatives and their opinions on their impact.

- At least one person in each stakeholder category, and most participants overall, noted that coordination of care and accountability for management of populations of patients is the right approach to achieving a high value health care system in New Hampshire;
- A number of providers expressed interested in taking on risk,¹¹ though one hospital was not interested because they do not have the infrastructure or skills needed to manage population health;
- Interviewees expressed both an interest in health system transformation, as well as reservations regarding the ability to do so, for example, due to the inability of the current claims system to use alternative payment methods;
- Carriers feel that despite a fair amount of consolidation among providers, there is a lack of clinical and administrative integration;

¹¹ Employer financial risk for costs of health coverage for employees—that is, whether the employer wants to risk owing addition funds if employees' health care costs rise or would prefer to let an insurance carrier assume that risk—is different from provider financial risk—which involves holding providers financially accountable for poor patient outcomes or patient cost of care.

- Multiple stakeholders said New Hampshire’s current health care system inadequately supports the needs of its citizens faced with mental health and substance abuse challenges;
- Stakeholders from multiple sectors spoke about the Certificate of Need process; many feel that the Health Services Planning and Review Board “rubberstamps” approval for unnecessary facilities.

What We Can Learn from Data on Delivery and Payment System Reform

The carrier survey shows that in 2011 New Hampshire insurance carriers relied primarily on traditional payment methods; for example, carriers made only 12% of payments with alternative payment methods or pay-for-performance. Carriers only used alternative payment methods only in ACO contracts; ACOs received 64% of their payments from these three carriers via a global payment arrangement with downside risk, and another 10% from contracts that included pay-for-performance provisions. Less than 1% of payments reported were for bundled payment models.

There are multiple pilot and demonstration projects currently underway across the state, in addition to ACOs and other collaborative efforts. Figure 1.4 shows a map of some of the ACOs and other affiliations in New Hampshire.

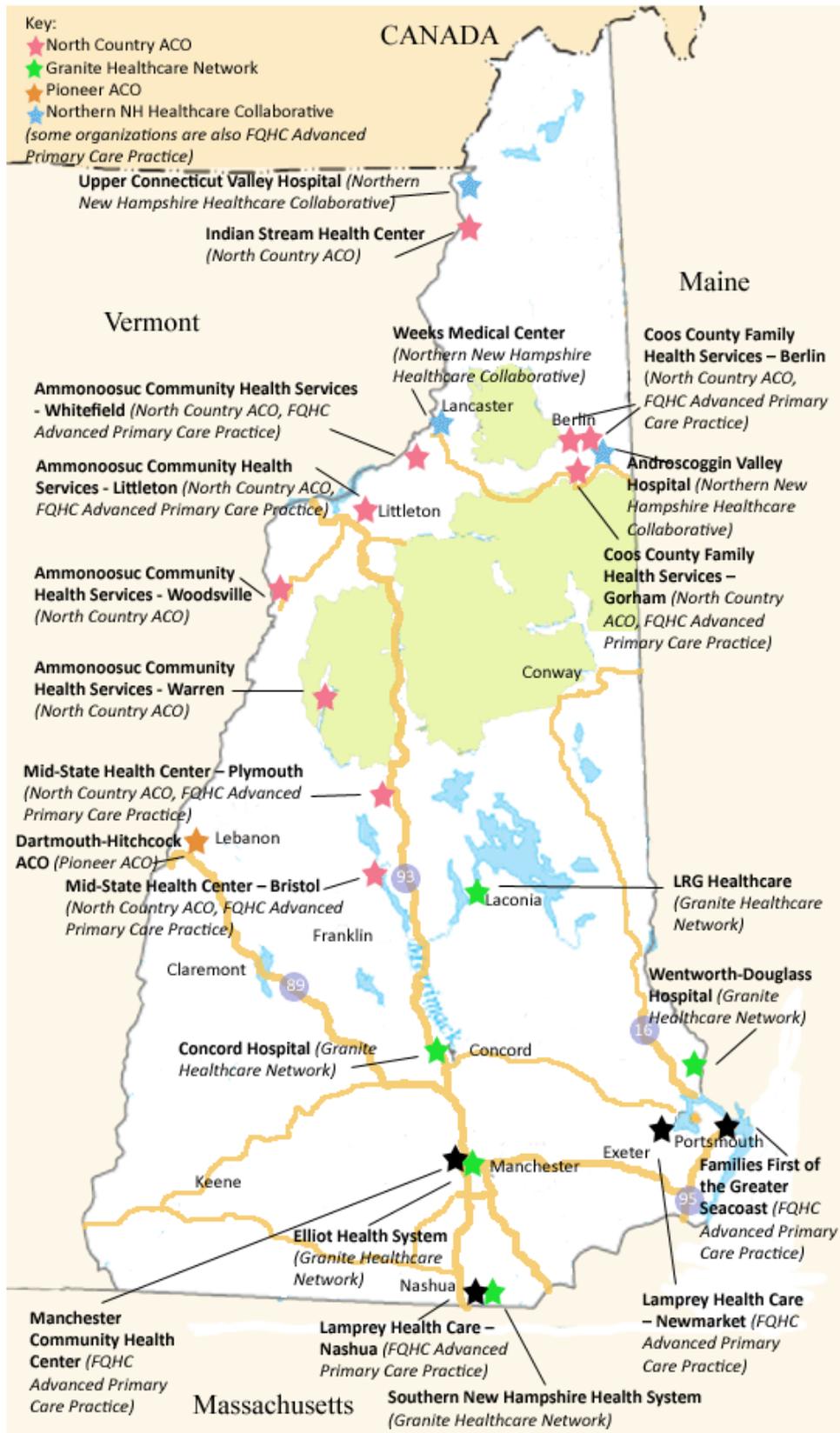
Stakeholder Recommendations

Stakeholders from one or more market sectors made recommendations in six main areas.

1. The state should develop a shared long term vision on promoting the health of the New Hampshire population, improving quality of care, and containing health care costs. Align policies and regulations to support the vision, for example, to guide decisions regarding investing in payers’ and providers’ infrastructure;
2. The state should continue to support transparency and the development of tools that make information, utilization and cost data more accessible to providers, payers and consumers;
3. The NHID should play a convening role in the development of new payment models, developing guidelines for new models, and supporting developmental pilots;
4. The NHID and other state agencies should review and evaluate stakeholder payment issues to determine whether to intervene in the market;
5. The state should increase investment in primary care;
6. The state should reform the Certificate of Need process.

NHID has an opportunity to provide the leadership that carriers, providers, and purchasers are seeking as New Hampshire undergoes systemic changes to decrease health care costs and improve patient outcomes and quality of care.

Figure 1.4: Map of Innovation Initiatives in New Hampshire



2. Background

The New Hampshire Insurance Department (NHID) contracted with the Center for Health Law and Economics at the University of Massachusetts Medical School (UMMS) and its partner Freedman HealthCare, LLC (FHC), to better understand the current health service provider payment system in New Hampshire and the impacts of that system on health insurance premium rates and health care costs. NHID charged the team from UMMS and FHC with gathering and analyzing data from a range of health care stakeholders, including insurers, health care providers, state regulators, and consumer associations, with a goal of identifying areas that stakeholders would like the NHID to consider for future system reforms.

FHC conducted and summarized stakeholder interviews, while UMMS conducted data analysis, managed the project, and compiled this report.

Scope and Objectives

A number of factors influence New Hampshire's insurance market, such as the strategies and payment methods adopted by large private and public payers, the geographic isolation of many providers, and competing consumer interests for both lower prices and greater choice. As providers accept more financial risk through alternative payment methods, employers and consumers are increasingly questioning the cost and value of health care coverage. Each of the stakeholders—government, carrier, consumer, and provider—has opportunities to influence the current system, and each in turn is influenced by other segments of the market.

The goal of this study is to address the following broad topics:¹²

- **How market power is distributed among stakeholders in New Hampshire**
What is the balance of power among stakeholders in creating insurance products and setting rates? How do stakeholder views compare to actual contracting dynamics? How do stakeholder actions affect prices and products?
- **What factors affect costs**
Is competition among carriers and providers successful in controlling costs? What role does plan design play in mitigating costs?
- **The use of alternative payment methods**
To what extent are alternative payment methods in use in New Hampshire? Are carriers and/or providers addressing both quality and cost?
- **How stakeholders feel the system should be reformed to improve quality and reduce cost**
What reform options do stakeholders recommend? Which options are feasible for the NHID or other state agencies to undertake?

Data sources

To develop this report, the project team gathered information from a variety of sources, including stakeholder interviews, data provided by carriers for this analysis, publicly available data previously published by the NHID, and other health system literature. The three main sources of information, described below, are (1) stakeholder interviews, (2) 2011 NHCHIS, and (3) a survey of carriers' 2011 data.

Stakeholder Interviews

The goals of the interviews were to understand the drivers of health insurance premium rates and health care costs in general, to learn the extent to which providers and carriers are undertaking care delivery and

¹² See the Glossary in **Appendix A** for a definition of terms relevant to the health insurance industry.

payment reform initiatives, and to gather stakeholder recommendations on actions they believe the state could take to improve the value of health care.

The project team selected stakeholders from three major categories: purchasers/consumers, carriers, and providers. In consultation with NHID staff, the team selected individuals and organizations based on their influence in the New Hampshire health care market, knowledge and experience with issues related to the drivers of health care costs, and involvement in reform initiatives. In addition, we interviewed a representative of a state agency, and included this response in the provider section to protect the individual’s confidentiality.

The team assured interviewees that all responses would be kept confidential, and that no comment would be attributed to a single individual. The project team aggregated all findings by stakeholder group.

Figure 2.1 contains the list of stakeholder organizations participating in the interview process.

Figure 2.1: Stakeholder organizations represented in interviews

Stakeholder Group	Organization
Payer	Aetna Anthem Centene Cigna Harvard Pilgrim Health Care Meridian MVP United HealthCare
Provider	Bedford Ambulatory Surgical Center Bi-State Primary Care Association Coos County Family Health Services Dartmouth Hitchcock Medical Center Lakes Region Hospital Lamprey Health Care Mid-State Health Center New London Hospital NH Hospital Association NH Medical Society Plymouth Regional Hospital Southern New Hampshire Medical Center Spere Memorial Hospital
Purchaser	NH Purchasers Group on Health Business and Industry Association of NH Hypertherm Hitchiner Manufacturing
Regulator	NH DHHS (<i>responses included in Provider section to protect confidentiality</i>)

The project team conducted 26 interviews with key stakeholders in the New Hampshire health insurer/hospital market. The project team developed interview questions for each stakeholder group to guide the conversation. Questions focused on the contracting environment, delivery system redesign, and new payment and delivery models that might influence the costs of health care coverage and delivery; interviews also covered stakeholder solutions to health care payment and delivery system challenges.

Appendix B contains a detailed description of process used for interviews, a full list of questions for each stakeholder group, and a sample briefing paper used to introduce the project to the stakeholders.

[New Hampshire Comprehensive Health Care Information System \(NHCHIS\)](#)

To create a profile of the current market, the team analyzed data¹³ from the state’s 2011 all-payer claims data, New Hampshire Comprehensive Health Care Information System (NHCHIS). These data include claims paid by commercial insurance and third party administrators for “residents of New Hampshire and for members who receive services under a policy issued in New Hampshire” that are for “any policy that provides coverage to the employees of a New Hampshire employer that has a business location in New Hampshire.”¹⁴

In addition to providing background regarding New Hampshire’s insurance market, the 2011 NHCHIS data also provide more precise information about topics brought up by stakeholders, including carrier market share, insurance products, and cost sharing. At times the NHCHIS data bolster stakeholder statements, while at other points the data present a different picture from the one that stakeholders describe.

[Carrier Survey](#)

The team requested additional information not available in the NHCHIS data from the five largest carriers in New Hampshire regarding their 2011 payment arrangements and insurance products. Three carriers responded to our survey; to protect their proprietary information, the team aggregated the data from these carriers.

In the survey, the team asked carriers to what extent they use various payment arrangements (charge based, fee schedule, and global payments, both with and without pay-for-performance and downside risk¹⁵) with different categories of providers:

- ACOs or Physician Hospital Organizations (PHOs)
- inpatient and outpatient hospitals
- physician practices

The survey also asked carriers for information on pay-for-performance, bundled payment, and tiered-network products, including the type of metrics used to assess performance.

A copy of the survey and survey instructions is in **Appendix C**.

[Summary of the New Hampshire Insurance Market](#)

In 2011, a total of 66% of New Hampshire residents had commercial insurance, while 23% were covered by public insurance (predominantly Medicare and Medicaid), and 11% were uninsured.¹⁶ Overall, there was a 2.9 percentage point decrease in employer-sponsored insurance for New Hampshire residents from 2010 to 2011 and a corresponding 2.8 percentage point increase in the uninsured.¹⁷ This increase in the uninsurance rate is potentially a major concern for the state, if other analyses confirm this trend. However, this result could be an anomaly due to a small sample size.

¹³ Note: Pharmacy and dental claims were not analyzed for this report.

¹⁴ New Hampshire Administrative Rule Chapter Ins 4000: Uniform Reporting System for Health Care Claim Data Sets.

¹⁵ See Glossary for a definition of these terms.

¹⁶ Kaiser Family Foundation, *Health Insurance Coverage of the Total Population (2010-2011)*, <http://kff.org/other/state-indicator/total-population/?state=NH>.

¹⁷ Kaiser Family Foundation, *Percentage Point Change Among Nonelderly 0-64 by Coverage Type (2010-2011)*, <http://kff.org/other/state-indicator/point-change-among-nonelderly/>.

As **Figure 2.2** shows, New Hampshire’s rate of employer-based coverage is substantially higher than the national average, and higher than the other New England states. New Hampshire’s rate of uninsurance is lower than the national average of 16%, but is higher than most other states in New England. A total of 7% of New Hampshire residents are enrolled in Medicaid, a rate lower than neighboring states and the national average of 16%.

Figure 2.2: Coverage in New England and Nationally¹⁸

Location	Employer	Individual	Medicaid	Medicare	Other Public	Uninsured
United States	49%	5%	16%	13%	1%	16%
New Hampshire	61%	5%	7%	15%	1%	11%
Maine	48%	4%	22%	14%	2%	10%
Massachusetts	58%	5%	20%	12%	NSD*	4%
Rhode Island	51%	4%	17%	15%	1%	12%
Vermont	49%	5%	24%	13%	NSD*	9%

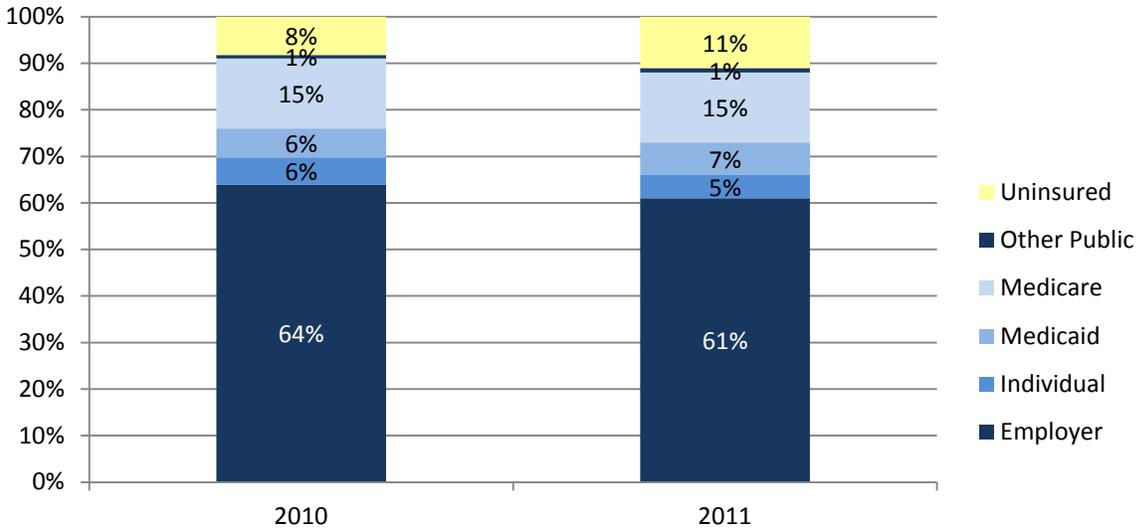
*Not sufficient data

While New Hampshire has a high rate of employer-sponsored insurance, the percent of residents with employer-based coverage fell by 2.9 percentage points between 2010 and 2011, as can be seen in **Figure 2.3**.¹⁹

¹⁸ Kaiser Family Foundation, *Health Insurance Coverage of the Total Population (2010-2011)*, <http://kff.org/other/state-indicator/total-population/>.

¹⁹ Kaiser Family Foundation, *Percentage Point Change Among Nonelderly 0-64 by Coverage Type (2010-2011)*, <http://kff.org/other/state-indicator/point-change-among-nonelderly/>.

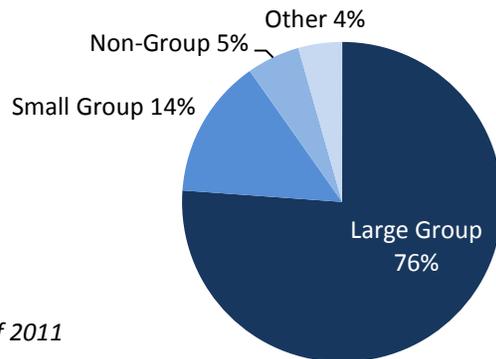
Figure 2.3: Sources of Health Insurance Coverage, 2010 and 2011



Kaiser Family Foundation, *Percentage Point Change Among Nonelderly 0-64 by Coverage Type (2010-2011)*

New Hampshire’s commercial insurance market covers over 641,000 members. The majority of members (488,567) are enrolled in Large Group products, with over 90,000 members in Small Group and fewer than 35,000 members in Non-Group, or individual, products²⁰. See **Figure 2.4**.

Figure 2.4: Percent of Commercial Members by Group Size



based on analysis of 2011 NHCHIS data

²⁰ Source: Authors’ analysis of 2011 NHCHIS

The three largest carriers, Anthem, Harvard Pilgrim, and Cigna, jointly comprise 80% of the commercial market, with more than 512,000 members combined (see **Figure 2.5**).

Figure 2.5: New Hampshire Insurance Carriers by Membership Size

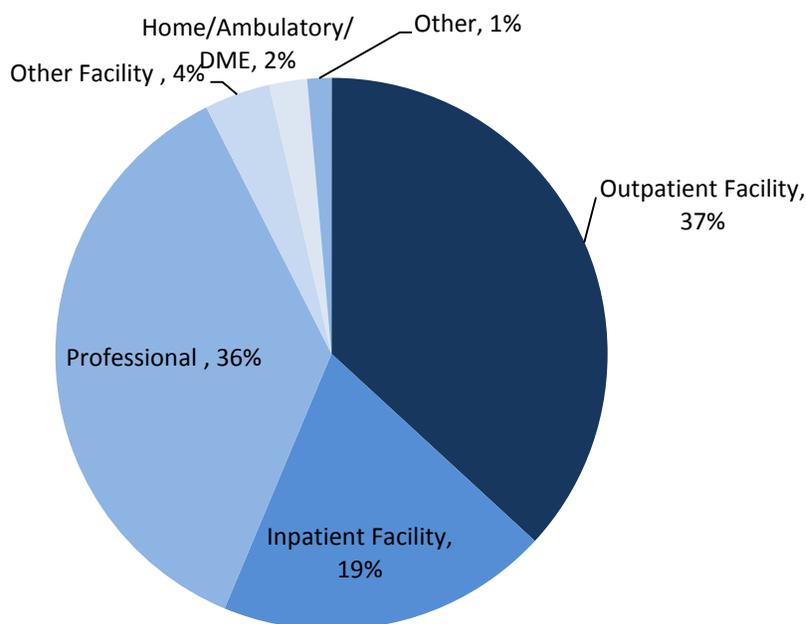
Carrier	Total	% of membership	cumulative total
Anthem	261,219	40.7%	40.7%
Harvard Pilgrim	131,143	20.4%	61.1%
Cigna	119,889	18.7%	79.8%
Aetna	49,945	7.8%	87.6%
United	27,256	4.2%	91.9%
Tufts	17,932	2.8%	94.7%
MVP	16,787	2.6%	97.3%
Other	9,744	1.5%	98.8%
Assurant	4,332	0.7%	99.5%
NH Health Plan	2,379	0.4%	99.8%
HealthMarkets	762	0.1%	99.9%
Golden Rule	195	< 0.1%	99.98%
American Republic	119	< 0.1%	100.0%
Guardian	10	< 0.1%	100.0%
Grand Total	641,712		

Source: Authors' analysis of 2011 NHCHIS

There are 26 acute care hospitals in the state, including 13 small Critical Access Hospitals (CAHs) serving rural regions. See **Appendix E, Figure 7.3** for a map showing all the hospitals in New Hampshire, including specialty hospitals.

Physician/professional services (36%) and outpatient hospital services (37%) are the two largest categories of health care spending, followed by inpatient hospital care (19%). See **Figure 2.6**. Note that these charges do not include prescription medications.

Figure 2.6: 2011 Charges by Service Type



Source: Authors' analysis of 2011 NHCHIS

Implications of the Affordable Care Act (ACA)

The fully-insured commercial insurance market and the Medicaid program in New Hampshire and other states will be subject to a number of provisions of the federal Affordable Care Act (ACA) that become effective on January 1, 2014. In this section, we highlight the major ACA provisions of interest that are set to begin in 2014.

Several ACA rules relate to premiums in the individual and small group markets. Starting in 2014, premium variations in the individual and small group markets must be limited to the following four factors: age (limited to a 3:1 variation), family size, tobacco use, and geographic area. In addition, the ACA will not allow premiums to vary by health status or gender. Insurers will be required to use a single risk pool for each of the Non-group and Small Group markets when developing insurance premiums.

Beginning in 2014, the ACA requires each state to have a health insurance marketplace or “Exchange” for individuals and small businesses to learn about and purchase qualified health plans that meet certain benefits and cost standards.

Whether a plan is offered within the state’s Exchange or outside it, the ACA requires all non-grandfathered Non-group and Small Group plans to cover certain health benefits defined in ten broad categories of care, referred to as “essential benefits.” The essential benefits requirements also apply to newly eligible Medicaid beneficiaries.

Other relevant ACA provisions relate to the Medicaid expansion²¹; tax credits for individuals and small businesses for health insurance; the elimination of annual limits on insurance coverage; and the ACA’s mandate for individuals to obtain basic health coverage or pay a penalty.

²¹ The Governor’s FY2014-2015 budget includes the expansion of Medicaid coverage to approximately 99,000 uninsured people. The Lewin Group, *An Evaluation of the Impact of Medicaid Expansion in New Hampshire, Phase*

With the various market and regulatory requirements of the ACA, as well as increased coverage of the uninsured, there will likely be changes in New Hampshire's commercial insurance market in terms of numbers of covered individuals, rates, and benefits offered, as well as demand for medical services.

I Report, November 2012. <http://www.dhhs.nh.gov/ombp/documents/nhimpactofmedicaidexpansionv8550719.pdf>. The New Hampshire Legislature did not include the expansion in the budget that was passed on June 26, 2013, but created a commission to study the proposed expansion.

3. Research Findings and Analysis

Below is a synthesis and analysis of stakeholder viewpoints about aspects of New Hampshire's health insurance market, with supplemental data from 2011 NHCHIS, the carrier survey of 2011 data, and other published literature from the New Hampshire Insurance Department and national sources.

Competing Tensions in the Marketplace

Health care costs were the major focal point for all stakeholders interviewed. Carriers want lower provider payment rates; providers are concerned about low-cost plan designs that might deter patients from seeking care due to high cost-sharing; and employers need health premiums to be financially feasible to afford coverage for staff. The actions and decisions of one group of stakeholders affect other sectors.

Efforts to contain health care costs are interrelated with efforts to improve quality of care. Stakeholders are thus wrestling with what industry reforms to enact and what role each stakeholder should play in increasing the value of health coverage – that is, improving health outcomes while reducing costs.

Many interview comments underscore the competing tensions among stakeholder philosophies of how the insurance market and health care delivery system should be organized. Stakeholder philosophies fall along a continuum as to whether the solution lies with:

- Having a free market that allows innovation or having greater government oversight to protect consumers
- Using lower-cost site of service facilities to reduce costs or using care coordination so providers can oversee all aspects of a patient's care
- Demanding more accountability for outcomes from providers or demanding more personal responsibility from consumers

Members of a stakeholder group might support a particular type of reform, such as care delivery transformations or products offered to consumers, but oppose other changes, such as provider financial risk for patient health outcomes or regulatory oversight of insurance products. Or a stakeholder might see value in both ends of the spectrum, such as allowing some free market innovations while also having some governmental regulatory oversight. As will be demonstrated throughout this report, these philosophies cross the stakeholder groups. For example, some carriers and providers are interested in free market reforms, while others want greater government involvement, to control costs and improve patient care.

A: Cost

Along with consumers nationwide, New Hampshire residents have seen health care costs – premiums, deductibles, and co-payments – increase in the past decade.

Almost every major point brought up by health industry stakeholders during their interviews touched on cost issues.

Stakeholder Viewpoints on Costs

During interviews, the project team asked stakeholders for their thoughts about costs within the health care system as a whole, as well as about costs paid by employers and employees.

During interviews with carrier representatives, many interviewees stated that costs rise when hospitals purchase independent physician practices. Many carriers stated that hospitals bill for services delivered by physicians or ambulatory care centers as if they were hospital outpatient services. Because carriers typically pay higher fees to hospitals than to freestanding physician practices, including these services under the hospital cost structure increases insurers' costs. Carriers also stated that hospitals bill for a facility fee when members receive services at physician practices outside the hospital grounds. The facility fee is intended to cover high hospital overhead costs, which external sites do not incur. Insurers typically pass these higher costs on to employers and consumers in the form of higher premiums.

One carrier said New Hampshire hospitals have higher margins than other states. Another carrier comment suggested the state should require hospitals to review and reduce administrative costs. Stakeholders representing two carriers and one provider interviewed specifically mentioned that although carriers are held to a standard for administrative costs, regulators do not scrutinize hospitals' administrative costs with the same level of attention.

“The supply and demand concept stands on its head in New Hampshire,” one carrier said.

There are current hospital efforts underway to reduce administrative costs, although only one provider, a hospital executive, mentioned efforts in this area. Namely, the state Office of Rural Health funded a grant for training in “lean” process improvement methods, to identify opportunities for efficiencies. Nine of the thirteen CAHs participated in lean training in the spring of 2012. Participating hospitals launched their lean projects in 2013. Even though data were not available at the time of the interviews to evaluate the effectiveness of the projects, the hospital executive interviewed was optimistic that the projects would yield positive results and reduce hospital costs.

Most providers, particularly hospitals, felt that higher premium costs are a direct result of underfunded public insurance programs, such as Medicaid. Five of the six hospitals interviewed mentioned the underfunding of Medicaid as a direct driver of commercial premium costs, and two mentioned a study by the New Hampshire Center for Public Policy that attributes a percentage of commercial premiums to cost-shifting.²² However, one provider said cost-shifting is “a ruse”.

²² Steve Norton, New Hampshire Center for Public Policy Studies, *Health System Cost-Shifting in New Hampshire*, March 2011, http://www.nhpolicy.org/reports/health_system_cost_shifting_finalv2.pdf.

One hospital representative attributed high costs in part to Anthem’s exclusive relationship with the Federal Employee Program (FEP), which enables Anthem to pay higher average rates to providers, driving up the payment level all providers then expect and thus increasing premiums. The interviewee illustrated the strategy using a radiology service as an example: If Anthem pays providers \$100 for chest X-rays for FEP members and \$60 for the same X-ray for a non-FEP member, the provider will receive \$80 on average for a chest X-ray. Providers then expect other carriers to pay \$80 as well, a \$20 increase over their existing \$60 rate. The interviewee said that when other carriers increase their premiums to cover the higher costs (e.g., \$20 increase for a chest X-ray), Anthem then shadows, or matches, those higher premiums, and receives a greater profit from the same premium rates than their competitors due to the profit they make from FEP members.

Two interviewees attributed costs to the single statewide geographic rating area. Both a carrier representative and hospital representative said during interviews that the statewide rating system leads to populations in the south subsidizing the higher cost of the North Country providers; since carriers cannot charge different premiums in different parts of the state, premiums are raised throughout the state to cover the cost of the more expensive contracts in the North Country.

“Patients are calling to see what the prices for services are” before seeking care.

Multiple stakeholders mentioned the high costs of premiums and deductibles in New Hampshire, citing premiums as the second highest in the country and noting that deductibles are higher than in Massachusetts. One carrier said its rate of membership in high deductible health plans is similar to the state average of 18%; however, a provider said “because of high deductible plans, more people are underinsured and bad debt grows.” However, carriers also mentioned that state employees have lower cost-sharing than private sector employees. They described the public sector design as an overly-generous, outdated system that is not sustainable. For example, they said state employees have a \$1 co-payment for prescription medication.

Employers expressed concerns regarding their ability to afford health insurance for their staff. Some employers are evaluating the financial risks of incurring federal fines by eliminating employer-sponsored insurance and directing their employees to purchase insurance through the Exchange.²³ Both of the purchasers interviewed have developed on-site access to primary care for their employees as a cost savings measure. Employers in the Small Group market have responded to products that control premium increases through the use of high deductibles and lower cost-sharing for site of service facilities.

Interviewees explained that municipalities and other state purchasers feel the expected financial impact of coming ACA requirements is daunting. Many universities have a large number of employees who work 30 hours a week. These employers will have to choose whether to provide health coverage to those employees or to reduce employee hours so they no longer fall under the ACA mandate for coverage of full-time employees. In addition, purchasers interviewed said that all New Hampshire municipalities

²³ Businesses with 50 or more full-time employees will be fined \$2,000 per employee (excluding the first 30 employees) if they do not offer coverage for employees who average 30 or more hours per week; for example, for an employer with 100 full-time employees, 70 would be counted towards the fine. Note that there is no penalty for not offering coverage to part-time employees. See <http://kff.org/health-reform/fact-sheet/explaining-health-reform-how-will-the-affordable-care-act-affect-small-businesses-and-their-employees/>.

have premium rates high enough to meet the criteria of “Cadillac plans”²⁴ under the ACA and are concerned that the municipalities might face a large excise tax on the amount of the premium that the ACA considers excessive.

Hitchiner Manufacturing

A self-insured business, Hitchiner Manufacturing focuses on wellness and prevention to reduce health care costs. Hitchiner’s premiums are so high that it is considered a Cadillac health plan and will be subject to the ACA’s excise tax on expensive health plans. To help mitigate costs, the company created an onsite wellness center staffed with nurse practitioners that employees and their families can access free of charge for both routine and acute care needs. The clinic is run in collaboration with Southern New Hampshire Health System. The goal of the free clinic is to improve employees’ health and reduce the company’s health care costs. In addition, Hitchiner considers it part of the company’s values to provide health coverage for its employees. The clinic opening in 2011 was covered by the press²⁵.

What We Can Learn from Data on Industry Costs

Data from NHCHIS and other studies on cost concerns create a clearer picture of some of the issues raised by stakeholders.

Hospital Margins

Stakeholders spoke about hospital practices affecting premium costs, including high hospital margins. A report on 2008 financial indicators placed New Hampshire community hospitals’ margins at 4.6%, compared to -0.4% for Maine, -1.4% for Vermont, -8.9% for Rhode Island, and -11.8% for Massachusetts.²⁶

A report on New Hampshire acute care hospitals’ 2009 operating margins show margins that range from -12.1% (Huggins Hospital) to 22.3% (Portsmouth Regional Hospital); half (13) of the hospitals had negative operating margins, while six had margins higher than 7%.²⁷ The state average operating margin for all 26 acute care hospitals in 2009 was 2.1%.²⁸

Cost-Shifting

Nationally, many health care stakeholders believe a substantial amount of provider cost-shifting occurs due to low public payment rates. The perception is that providers recoup Medicaid and Medicare losses by seeking higher payments from private carriers.

²⁴ Beginning in 2018, a new federal excise tax will be assessed on insurance companies for health plans that are extremely expensive (in excess of \$10,200 for self-only coverage, \$27,500 for families). These plans are popularly referred to as “Cadillac plans”. See <http://www.healthcare.gov/news/brochures/info-for-small-businesses.pdf>.

²⁵ “Hitchener opens a clinic for workers.” *New Hampshire Union Leader*. October 5, 2011. <http://www.unionleader.com/article/20111006/NEWS02/710069989>

²⁶ Arkansas Hospital Association, *Comparative Financial Indicators, U.S. Community Hospitals, 2008*, <http://www.arkhospitals.org/archive/arkhospmagpdf/Summer10stat16.pdf>.

²⁷ Katharine London, et al., University of Massachusetts Medical School, *Analysis of Price Variations in New Hampshire Hospitals*, April 2012, <http://www.nh.gov/insurance/lah/documents/umms.pdf>.

²⁸ Katharine London, et al., University of Massachusetts Medical School, *Analysis of Price Variations in New Hampshire Hospitals*, April 2012, <http://www.nh.gov/insurance/lah/documents/umms.pdf>.

The New Hampshire Center for Public Policy, mentioned by two interviewees, issued a report illustrating public payer rates that are below the average cost of care, and commercial rates that are above the average cost of care--thus attempting to demonstrate how costs are shifted from public to private carriers.²⁹

However, other studies of the issue have shown a more complex picture.

An April 2013 study disputed the cost-shifting theory when it found that a 10% reduction in Medicare payment rates led to a 3% or 8% *reduction* in private payment rates.

- A comprehensive literature review published in 2011 demonstrated that while cost-shifting does occur, it typically occurs at a lower rate than generally assumed and only when a provider possesses market power to demand higher prices from a carrier. Based on the review of the literature, the author estimated that when cost-shifting occurs, the “shift” from public to private payers is likely 20 cents on the dollar.³⁰
- A 2010 study by Vivian Wu found some cost-shifting occurred when Medicare rates were reduced as part of the Balanced Budget Act of 1997. Hospitals with an average Medicare payer mix were able to shift on average 21% of the loss to private payers. However, poorer hospitals that were more dependent on Medicare for funding were unable to cost-shift despite their larger reduction in funding.³¹
- An April 2013 study disputed the cost-shifting theory when it found that a 10% reduction in Medicare payment rates led to a 3% or 8% reduction in private payment rates between 1995 and 2009. The study noted that hospitals may have lowered private rates to remain competitive in the commercial market.³²
- A 2012 study for the NHID by the University of Massachusetts Medical School found that the more Medicaid patients a hospital treated, the lower its commercial outpatient prices. While there was a positive correlation between the percent of Medicare patients and commercial inpatient and outpatient prices, the percent of uninsured patients had no impact on the hospital’s commercial insurance prices.³³

These studies collectively indicate that while cost-shifting from public to private rates may occur, it likely has a lower impact on commercial prices than generally supposed.

Provider Rates

Carrier payments to providers are a major component of system-wide health care costs. In exchange for business (i.e., patients), carriers demand discounts from providers from their base charge for services.

²⁹ Steve Norton, New Hampshire Center for Public Policy Studies, *Health System Cost-Shifting in New Hampshire*, March 2011, http://www.nhpolicy.org/reports/health_system_cost_shifting_finalv2.pdf.

³⁰ Austin Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*. The Milbank Quarterly. 89.1. March 2011, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/>.

³¹ Vivian Wu, *Hospital cost shifting revisited: new evidence from the balanced budget act of 1997*, January 2010, <http://link.springer.com/content/pdf/10.1007%2Fs10754-009-9071-5.pdf>.

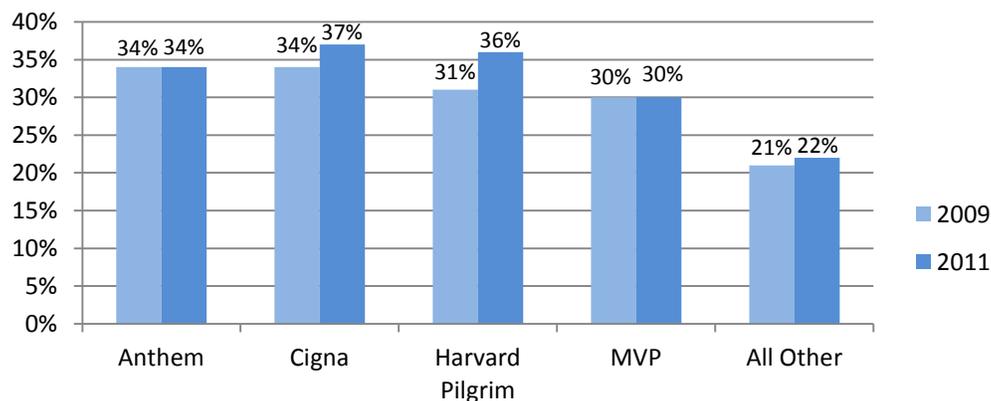
³² Chapin White, Health Affairs, *Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates*, May 2013, <http://content.healthaffairs.org/content/32/5/935.full>.

³³ Katharine London, et al., University of Massachusetts Medical School, *Analysis of Price Variations in New Hampshire Hospitals*, April 2012, <http://www.nh.gov/insurance/lah/documents/umms.pdf>.

Thus a carrier with more power, usually evidenced by market share, can demand larger discounts and accrue more members attracted by the lower premiums that carrier can afford to charge. Small carriers face difficulty in increasing their membership, in part due to non-competitive contracts with providers.

Analyses of carrier discounts by product type conducted by the NHID for 2009 and 2011 show large differences in how much carriers pay providers, and thus their competitive advantage for members. For example, in 2011, Cigna and Harvard Pilgrim negotiated discounts of 37% and 36% respectively for PPOs, while MVP's discount rate was 30%. On the other hand, Cigna's POS discount rate of 27% is far below Anthem and Harvard Pilgrim's discount of 41%. In 2011, Cigna reduced its POS discount rate to 3 percentage points below 2009 levels, while increasing its PPO discount by 3 percentage points. Harvard Pilgrim negotiated increases in its discount rates of 5 percentage points for both PPOs and POS contracts.³⁴ **Figure 3.1** shows the PPO discount rates in 2009 and 2011.

Figure 3.1: PPO Carrier Discounts from Providers, 2009 vs. 2011



NHID, *Payments to providers: an inside look at carrier discounts and Payments to providers part II: another look at carrier discounts*

Southern vs. Northern Prices

Some stakeholders felt southern residents subsidize higher-cost providers in the north, and multiple interviewees stated that providers in rural regions without competition are able to command higher contracts. However, an analysis of prices paid to hospitals in 2009 in the northern, central/western, and southeastern regions found no statistically significant differences between the regions. The average prices for commercial coverage was on average higher in the north (\$11,188) than in the southeastern (\$9,984) and central/western (\$9,424) regions, but the range of prices in the north fell within the ranges for the other two regions, albeit at the upper end of the spectrum. The hospital with the highest average commercial prices was in the southeastern region.³⁵

Coos and Carroll Counties have a larger percentage of residents over 65 (21.4% and 20% respectively), much higher than the southern Rockingham, Strafford and Hillsborough Counties, whose elderly

³⁴ NHID, *Payments to providers part II: another look at carrier discounts*, August 2012, http://www.nh.gov/insurance/reports/documents/nhid_prov_disc_study_partII.pdf.

³⁵ Katharine London, et al., University of Massachusetts Medical School, *Analysis of Price Variations in New Hampshire Hospitals*, April 2012, <http://www.nh.gov/insurance/lah/documents/umms.pdf>.

comprise 12% - 13% of the county population.³⁶ However, given that only approximately 8% of the state's population lives in Coos County and northern Carroll and Grafton counties³⁷, they likely have a limited impact on health care costs in the entire state, despite the higher proportion of residents who are older, and therefore more likely to need and use medical care, than the rest of the state.

What We Can Learn from Data on Consumer Costs

Consumers make two types of payments for health care coverage: premiums and cost-sharing. Employers offering insurance and employees enrolled in the insurance plans typically share the cost of the premium, while employees are responsible for cost sharing for health care services (co-payments, deductibles, etc.). Employers may attempt to lower premium costs by reducing the benefit richness, measured by actuarial value, which is the value of medical services covered under a health plan compared to the costs borne by members. Data from the NHID show that the benefit richness decreased in HMO, POS, and PPO products for both fully insured and self-insured Large Group plans between 2010 and 2011, while Large Group EPOs and many self-insured products of various Group sizes, except for HMOs, saw some increase in benefit richness.³⁸

As detailed below, New Hampshire is at the high end of the cost spectrum for consumer costs, but is not alone in struggling with the impact of such high costs on consumers.

New Hampshire's average family premium is the second highest in the country.

Premiums

Multiple stakeholders expressed concern about New Hampshire's high deductibles and premiums. According to a Commonwealth Fund report on 2011 premiums, New Hampshire's average family premium of \$16,902 is the second highest in the country, after Massachusetts, and New Hampshire is one of eight states with family premiums greater than \$16,000.³⁹ Similarly, New Hampshire's average individual premium of \$5,818 is the fourth highest in the country, after Alaska, Rhode Island and Massachusetts. New Hampshire's individual premium is 10% higher than the national average⁴⁰. Note

³⁶ United States Census Bureau, *State and County Quick Facts, 2011*, <http://quickfacts.census.gov/qfd/states/33/33019.html>.

³⁷ Estimated from data from United States Census Bureau, *State and County Quick Facts, 2012 estimate*, <http://quickfacts.census.gov/qfd/states/33000.html>.

³⁸ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nh_id_suprpt.pdf and New Hampshire Insurance Department, *Supplemental Report of the 2010 Health Insurance Market in New Hampshire*, April 2012, http://www.nh.gov/insurance/lah/documents/sup-rep_10.pdf.

³⁹ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_s_tate_trends_premiums_deductibles_2003_2011_1210.pdf.

⁴⁰ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_s_tate_trends_premiums_deductibles_2003_2011_1210.pdf.

that in 2012, 46% of employees had individual coverage, 17% had single plus one (coverage for member plus a spouse or child), and 36% had family coverage.⁴¹

Premiums in New Hampshire have increased faster than inflation. 2011 average premiums were \$5,818 for single plans and \$16,902 for family plans.⁴² From 2003 to 2011, single and family premiums are 21% and 28% higher, respectively, than they would have been if premiums grew at the same rate as inflation.⁴³ In addition, the rate of premium growth in New Hampshire between 2003 and 2011 is higher than the U.S. average growth for individual and family premiums during that time period.

In 2011, New Hampshire employees with individual plans paid an average of 21% of their premium (\$1,237), while employees with family plans paid an average 25% of their premium (\$4,205). These percentages are comparable to national figures.⁴⁴

Overall, New Hampshire premiums represent a lower percent of income than health care premiums represent nationally. In the U.S., average premiums for individual and family plans in 2011 were 21.5% of the median income for U.S. residents under 65. Yet in New Hampshire, all premiums represented 17.9% of the median income in the state, lower than all the other New England states as well as the country as a whole.⁴⁵ Notably, New Hampshire's median household income of \$62,647 is significantly higher than the U.S. median household income of \$50,502.⁴⁶ However, the median household income varies widely throughout the state, from \$39,995 in Coos County to \$75,982 in Rockingham County. Lower-income households in any region will thus be forced to pay a larger percent of their income on premiums and other health care expenses. Note that there is a moderate positive correlation between income and family premiums nationally.⁴⁷ This correlation suggests that premium costs may be related to regional price and income differences.

Premiums for self-insured plans (\$393) are 3% lower than for fully insured plans (\$406)⁴⁸, in part due to lower administrative expenses. The average premium for self-insured plans dropped 13% from \$451 in 2010 to \$393 in 2011, while the average premium for fully insured plans rose 4% from \$391 to \$406. See

⁴¹ Kaiser Family Foundation, *2012 Employer Health Benefits Survey*, September 2012, <http://kff.org/report-section/ehbs-2012-section-3/>

⁴² Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210.pdf.

⁴³ Calculation based on Consumer Price Index for All Urban Consumers, U.S. City Average for Medical Care, 2003–2011, Bureau of Labor Statistics, <http://www.bls.gov/cpi/>.

⁴⁴ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210.pdf.

⁴⁵ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210.pdf.

⁴⁶ U.S. Census Bureau, 2011 American Community Survey 1-Year Estimates, *Selected Economic Characteristics*, http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_DP03&prodType=table.

⁴⁷ Correlation coefficient of 0.49, $p < .0002$.

⁴⁸ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nh_id_suprpt.pdf.

Figure 3.2. This decrease in premiums corresponds with the decrease in benefit richness described earlier.

Figure 3.2: Self-Insured vs. Fully Insured Premiums by Group Size

	Plan Type	Self-Insured Average Premium*	Fully Insured Average Premium
Large Group	HMO	\$431	\$453
	POS	\$456	\$450
	PPO	\$342	\$397
	EPO	\$421	\$332
	Indemnity**	\$458	\$1,458
Small Group	HMO	\$478	\$424
	POS	\$489	\$535
	PPO	\$533	\$433
	EPO	No membership reported	\$390
	Indemnity**		\$331
Non-Group	HMO	No membership reported	\$191
	POS		No membership reported
	PPO		\$275
	EPO		\$460
	Indemnity**		\$216
Total		\$393	\$406

*Premium equivalent was calculated for self-insured policy holders

**Indemnity values are disproportionately affected by outlier data due to limited membership.

Source: NHID⁴⁹

Employee Cost-Sharing

In addition to paying a portion of the premium, employees share the cost of coverage through co-payments, co-insurance and deductibles incurred during visits to providers.

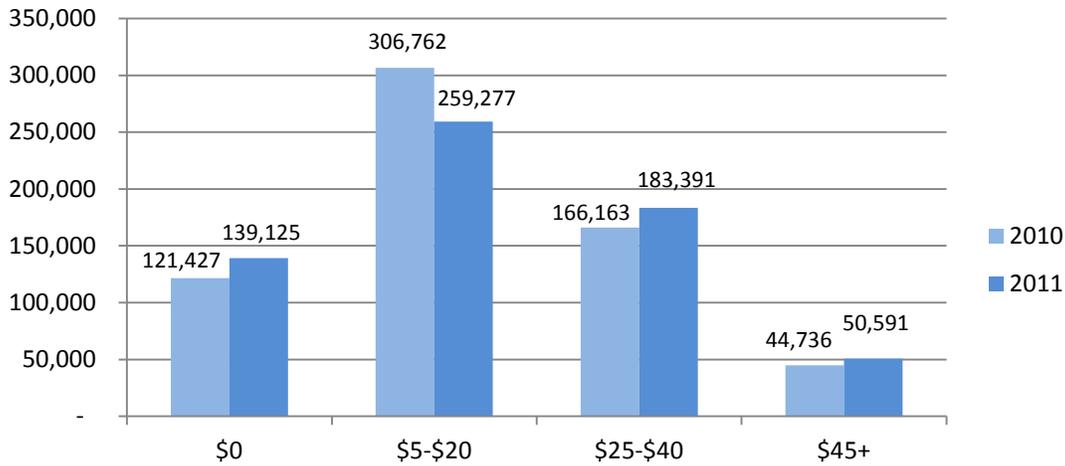
Co-payments

Co-payment amounts increased between 2010 and 2011 in New Hampshire. As **Figure 3.3** shows, despite an increase of over 17,000 members with no co-payment, fewer members had lower co-payment amounts (\$5-\$20) and more members had higher co-payment amounts. In particular, over 17,000 additional members had co-payments of \$25 or higher in 2011.⁵⁰

⁴⁹ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nhid_suprpt.pdf.

⁵⁰ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nhid_suprpt.pdf.

Figure 3.3: Number of Members by Co-payment Amount, 2010 vs. 2011



NHID, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*

Stakeholders brought up the issue of public sector employees having lower cost sharing amounts. According to benefit guide information, state employees in Anthem’s HMO and POS pay \$15 for a primary care visit and \$30 for a specialist visit, but do not have a co-payment for most other outpatient care, inpatient care and skilled nursing.⁵¹ State employees pay \$10 for generic medication and \$25 for brand name medication at retail stores; through Caremark’s mail service pharmacy, state employees pay \$1 for generic medication and \$40 for brand name medication.⁵² By comparison, Anthem’s website lists \$30 for primary care visits and \$40 for specialist visits for Anthem Premier, and 0% or 20% for network inpatient and outpatient care (depending on the coinsurance level chosen by members); members pay \$15 or 40% coinsurance for generic and brand name medications, whichever is greater.⁵³

Studies have shown that as co-payments increase, patients reduce their use of care. For example, substance abuse patients in outpatient treatment were more likely to stop treatment as their co-payments increased⁵⁴, while a different study showed that consumers were more likely to continue taking their prescription medications when co-payments were lowered.⁵⁵

⁵¹ Anthem Blue New England/Network Blue New England, *State of NH Summary Benefits/Active Employees HMO*, January 2013, <http://admin.state.nh.us/hr/documents/SIHNV608N%20State%20of%20NH%20ACTIVES.pdf> and Blue Choice New England, *State of NH Summary Benefits/Active Employees HMO*, January 2013, <http://admin.state.nh.us/hr/documents/SIBNV145N%20State%20of%20NH%20ACTIVES.pdf>.

⁵² CVS Caremark, *Active Employees: Your Personal Prescription Benefit Program*, <http://admin.state.nh.us/hr/documents/Caremark%20LGC%20Prescription%20Drug%20Benefit%20Summary.pdf> (June 2013).

⁵³ Anthem Blue Cross Blue Shield, *Benefit Guide for New Hampshire*, February 2013, <http://docs.anthem.com/wellpoint/docs/viewDocument?mcItemNbr=NHBG90010SP>.

⁵⁴ B.M. Barr, Robert Wood Johnson Foundation, *As Co-Payments Rise, Participation in Treatment Falls and More Substance Abusers Relapse*, December 2005, <http://www.rwjf.org/en/research-publications/find-rwjf-research/2005/12/as-co-payments-rise--participation-in-treatment-falls-and-more-s.html>.

⁵⁵ J.F. Farley, et al, *Medication Adherence Changes Following Value-Based Insurance Design*, American Journal of Managed Care, May 2012, <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/05/medication-adherence-changes-following-value-based-insurance-des.html>

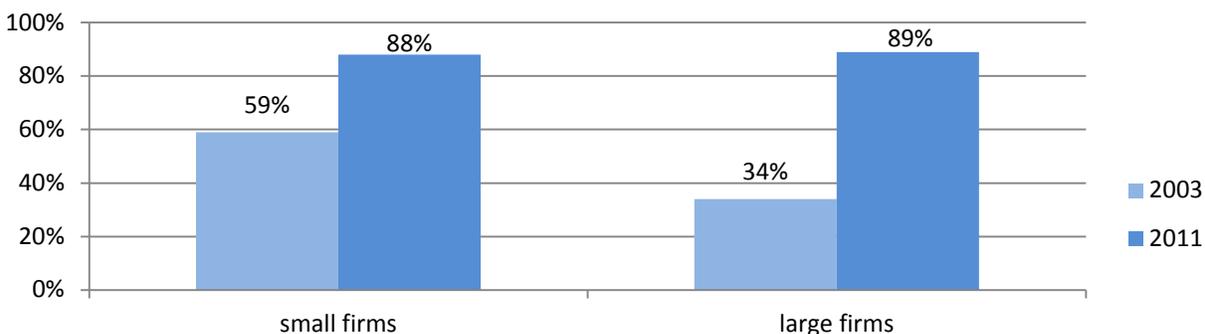
Co-insurance

The average co-insurance in New Hampshire in 2011 was 6.7%, slightly higher than the 2010 average of 6.2%. Approximately one-fifth of the population both years had a 20% co-insurance rate, although approximately two-thirds had no co-insurance. Co-insurance was more frequently used in Non-group plans (10.9% average rate), compared with Large Group (7.2%) and Small Group (2.6%); note, however, that Small Group products have higher deductibles than Large Group products, offsetting the lower co-insurance rates.⁵⁶

Deductibles

From 2003 to 2011, the percent of employees with deductibles has increased almost 50% for employees in small firms (fewer than 50 employees) and 162% for employees in large firms (50 or more employees). **Figure 3.4** shows that the percent of employees with deductibles has increased significantly from 2003 to 2011.⁵⁷

Figure 3.4: Percent of employees with a deductible, 2003 vs. 2011



Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*

As several interviewees pointed out, deductibles are higher in New Hampshire than in other states, such as Massachusetts. New Hampshire's average deductible for family plans, \$2,887, is 25% higher than the average Massachusetts deductible of \$2,177. New Hampshire's average deductible is 35% higher than Rhode Island's, 8% higher than Maine's, and approximately equal to Vermont's average deductible. New Hampshire is one of 23 states with an average deductible for family plans that is higher than the U.S. average of \$2,220.⁵⁸

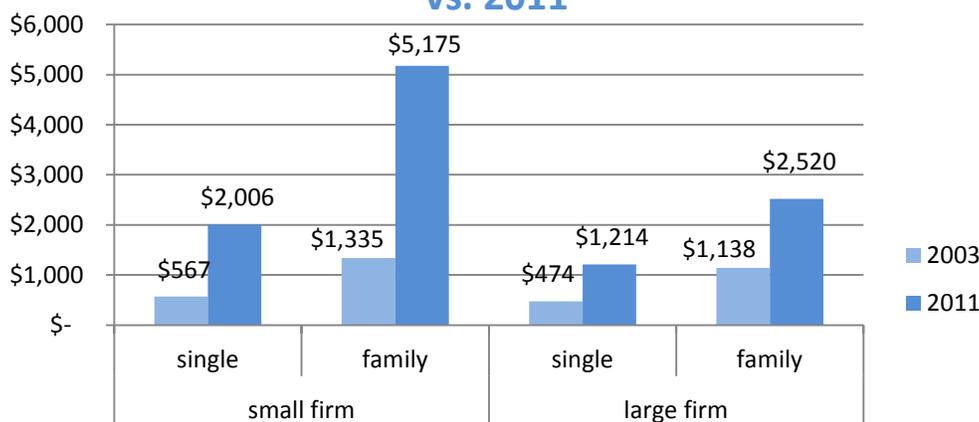
⁵⁶ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nh_id_suprpt.pdf.

⁵⁷ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210.pdf.

⁵⁸ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210.pdf.

The average deductible amount has more than tripled for small firms, and more than doubled for large firms, as can be seen in **Figure 3.5**.⁵⁹

Figure 3.5: Mean Deductible Amount for Individuals and Families by Firm Size, 2003 vs. 2011



Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*

Among self-insured plans, 100% of the approximately 32,000 state employees, 89% of the approximately 76,700 municipal employees, and 30% of the more than 232,000 employees at private businesses pay no deductible.⁶⁰ However, state and municipal employees pay higher average premiums in their POS plans compared to average private-sector employee premiums; the higher premiums partially compensate for the lack of deductibles.

New Hampshire’s average deductible for family plans is 25% higher than the average Massachusetts deductible.

High Deductible Health Plans

Faced with rising premiums, employers may choose to offer plans with high deductibles but lower premiums. High deductible health plans, defined by the IRS in 2011 as \$1,200 for an individual and \$2,400 for a family, increased their market share in New Hampshire from 2010 (11% of members) to 2011 (18% of members).⁶¹

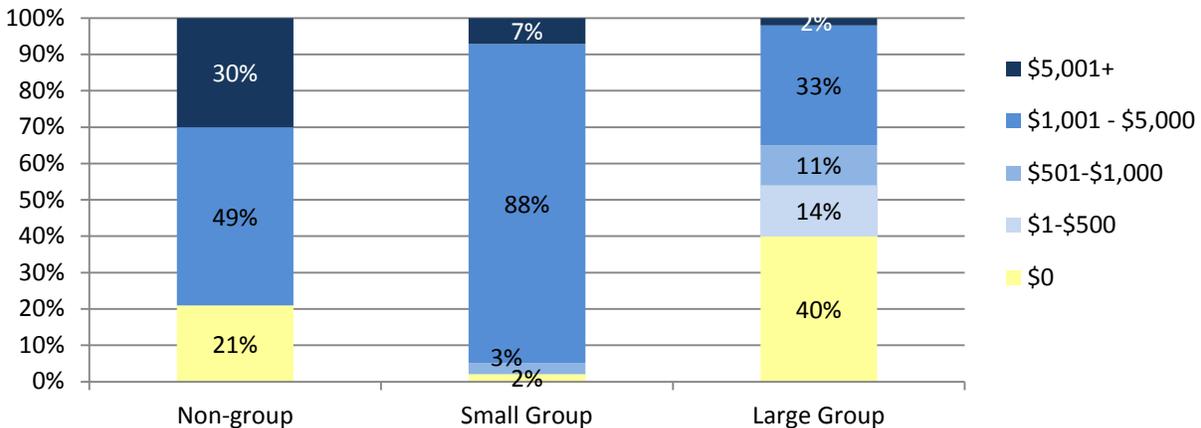
⁵⁹ Cathy Schoen, et al., Commonwealth Fund, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs*, November 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/premiums/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210.pdf.

⁶⁰ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nh_id_suprpt.pdf.

⁶¹ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nh_id_suprpt.pdf.

Figure 3.6 shows the percent of members by deductible level, for the Non-Group, Small Group and Large Group markets. The percent of members with deductibles of more than \$3,000 increased from 20% to 37% for Small Group plans and from 8% to 12% for Large Group plans from 2010 to 2011.⁶² As expected, higher deductibles are more common for Non-Group and Small Group members than for Large Group plans.

Figure 3.6: Group Size Distribution of Members by Deductible Level, 2011



Values adjusted from NHID, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire* so totals equal 100%

Actual Patient Payments Incurred and Barriers to Care

Although members might have high deductible, co-payment and co-insurance rates built into their plans, the actual amount of cost sharing incurred is based on each person’s use of medical care over the year. Someone who is healthy with a high deductible or co-insurance is more likely to incur lower out-of-pocket expenses than someone with chronic or acute illnesses whose plan has lower cost-sharing percentages.

Figure 3.7 shows the average amount incurred by patients in 2011, based on NHCHIS data. Note that the figures reflect the charges that patients incurred, but do not necessarily represent the actual amounts patients paid.

⁶² New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nhid_suprpt.pdf; figures adjusted so totals equal 100%.

Figure 3.7: Average Consumer Payment Amounts by Group Size

Group Size	Co-payment	Co-insurance	Deductible	Total Out of Pocket Costs
All members	\$103	\$80	\$253	\$436
Large Group	\$98	\$83	\$188	\$369
Small Group	\$155	\$53	\$456	\$665
Non-Group	\$59	\$125	\$700	\$883

Source: Authors' analysis of 2011 NHCHIS

Despite the increase in high deductible health plans, the majority of patients (70%) paid no deductible in 2011, while approximately 23% paid \$500 or less. See **Figure 3.8**, which has a comparison of the number of members whose plans have deductibles at each level and the number of members who actually incurred each deductible level in 2011.⁶³ For example, while 36% of members were in plans with deductibles greater than \$1,500, only 1.4% of members incurred deductibles that high, and fewer than a thousand members incurred deductibles higher than \$3,000.

Figure 3.8: Deductible levels in plan design versus actual amount incurred

Deductible <i>values in bold indicate high deductible levels for a family plan</i>	# of members with deductible amount in plan design, 2011 (Supplemental Report of the 2011 Health Insurance Market in NH)	% of members with deductible amount in plan design, 2011	# of members incurring deductible amount, 2011 (2011 NHCHIS)	% of members incurring deductible amount, 2011
\$0	205,324	33%	438,935	70%
\$1-\$500	67,727	11%	147,394	23%
\$501-\$1,000	56,276	9%	25,848	4%
\$1,001-\$1,500	76,525	12%	9,249	1%
\$1,501-\$3,000	114,798	18%	8,123	1%
\$3,001-\$5,000	78,906	13%	691	< 1%
>\$5,000	30,786	5%	102	< 1%
Total	630,342	100%	630,342	100%

*total based on figures in Supplemental Report of the 2011 Health Insurance Market in NH

While cost-sharing is widely used and increasing, a body of research on the impact of cost-sharing shows that higher cost-sharing often results in patients delaying care, not filling prescriptions, or avoiding care altogether. A Kaiser Family Foundation report summarizes studies on this issue. Kaiser highlighted one study that shows that higher Medicaid cost sharing reduces the use of both non-essential services as well as essential, needed care. A study of employer-based commercial insurance found members with chronic diseases reduced their use of certain prescription medications after co-payments were doubled; diabetics reduced their use of anti-diabetes medications by 23 percent.⁶⁴

⁶³ To identify members with incurred deductibles, the authors summed the deductible amounts reported on member claims for a unique count of members.

⁶⁴ Kaiser Family Foundation, *Premiums and Cost Sharing in Medicaid: A Review of Research Findings*, February 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf>.

B: Competition

Competition among carriers as well as providers is often a driver for cost reform in the health care industry. Payers who are able to choose among multiple providers can select those they feel provide the highest quality service for the lowest cost, and can reject provider demands for payment increases. Similarly, when several carriers compete for members in the same market, the carriers must demonstrate the quality of their services and risk losing members if they increase costs without adding value, or benefit richness, to their products.

In New Hampshire, local factors have created markets with limited competition among both carriers and providers. This market structure results in many providers having the power to demand certain payment levels, while smaller carriers feel dominated by the largest player.

Stakeholder Viewpoints on Carrier Competition

During the interview process, the project team asked stakeholders for their opinions on how competitive the insurance market is. The questions addressed the contracting environment in New Hampshire, how the level of competitiveness has affected costs, and the role of dominant carriers.

“Purchasers are driven by cost,” one carrier said during the interview.

Most providers interviewed said they have not observed competition among insurance companies. However, the carriers themselves felt they are very competitive. One carrier said the “three carriers with significant membership” are “all very competitive.” Carriers interviewed said they compete on service and medical costs, complying with the ACA-mandated Medical Loss Ratio (MLR) and requirements for statewide networks for certain plan designs/products. Carriers also said that purchasers are price-sensitive and will switch carriers for a small amount of savings offered by a competing carrier; this particularly holds true for self-insured accounts. A carrier explained, “Purchasers are driven by cost. [We] *can* win with lower premiums. There is not necessarily loyalty to a payer in the Small Group market.” A purchaser said the “decision is driven by cost for small groups – there is no real difference among products.” A carrier described carrier competition by saying “purchasers are willing to move for 2% premium differential.”

Anthem was also described as affecting the insurance environment through its push to include site of service incentives in all Small Group products. One stakeholder commented, “Anthem is a market maker – they can study products in multiple markets and spin them out quickly.” Site of service has been so successful in reducing costs that Harvard Pilgrim Health Care also came to market with a similar plan design.

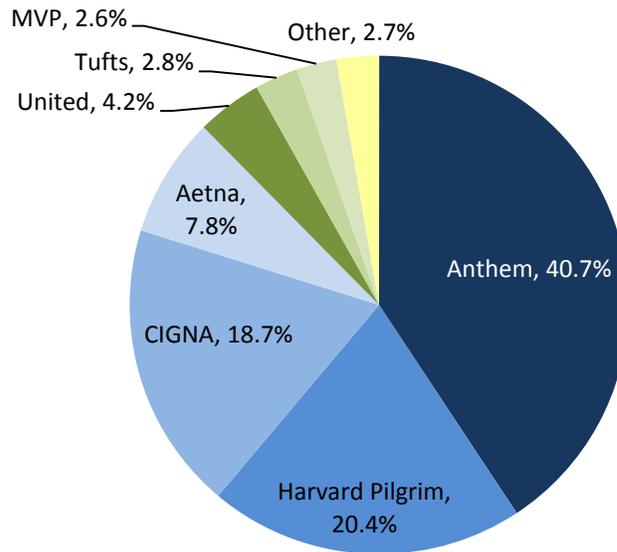
Interviewees from multiple stakeholder categories mentioned that due to New Hampshire’s small population, the addition of new carriers would not improve health care costs or delivery and the risk pool is not large enough to support additional carriers.

What We Can Learn from Data on Carriers’ Market Shares

There is some evidence to indicate that the New Hampshire insurer market is not competitive. 2011 NHCHIS data identify Anthem as the largest carrier in the New Hampshire insurance market, with a 40.7% market share. See **Figure 3.9**. The next largest carriers are Harvard Pilgrim, with a total market

share of 20.4%, and Cigna, with an 18.7% market share of members. Four small carriers each have between 2% - 8% of membership, while the smallest carriers have less than a thousand members each.

Figure 3.9: Commercial Health Insurance Carrier Market Share



based on analysis of 2011 NHCHIS

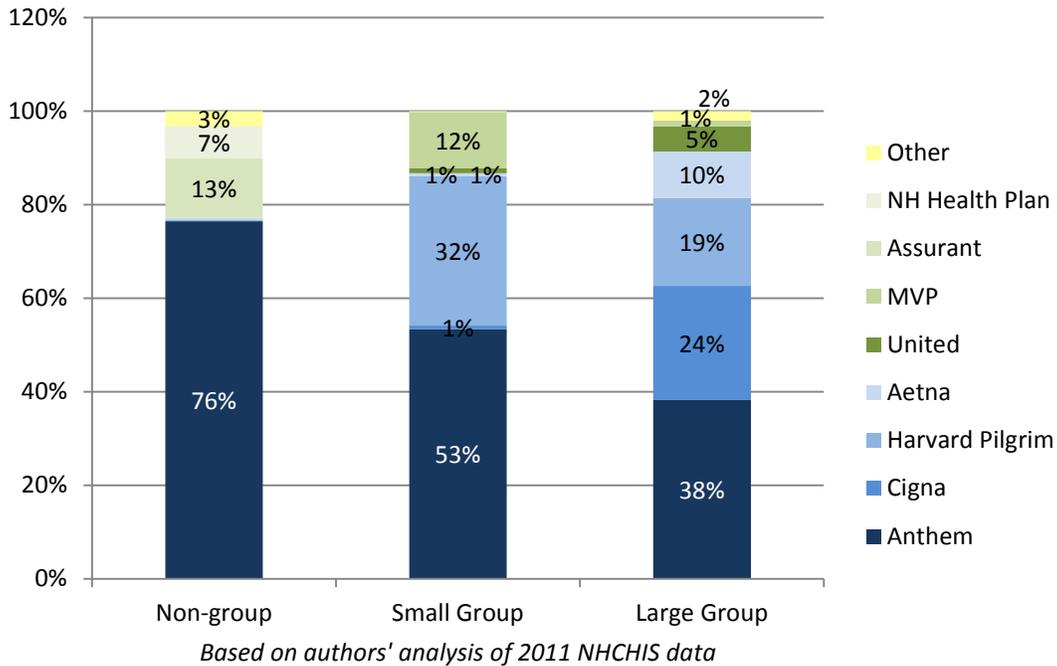
Multiple interviewees referenced Anthem as being the dominant carrier in the market; indeed, Anthem's market share is more than twice its nearest competitors, Harvard Pilgrim and Cigna.

However, a more nuanced view of the state's insurance market shows more competition than indicated by stakeholders. For example, the second and third-largest carriers have a combined market share that about equals Anthem's share.

In addition, there are differences in the Non-group, Small Group, and Large Group markets. **See Figure 3.10.**

- In the Non-group market (5% of the commercial market), Anthem has a 76% share of the market, but the next largest carrier is Assurant, with a 13% market share.
- In the Small Group market (14% of the commercial market), Anthem has 53% of the market, Harvard Pilgrim has 32%, and MVP is in third place with 12%.
- In the Large Group market (76% of the commercial market), there is a fourth strong carrier, Aetna, with 10% of the market.

Figure 3.10: Market Share by Group Size



There is similar diversity between the self-insured (58%) and fully-insured (41%) markets. While Anthem has a large market share in both the self- and fully insured markets, Harvard Pilgrim does more of its business with fully insured plans while Cigna and Aetna do approximately four to six times as much of their business in the self-insured market than they do in the fully insured market.

Finally, there is some variation by region, with carriers more prevalent in certain parts of the state. For example, while Anthem has 41% of the membership in the state, it has a higher percent of members in the North Country, in Coos County (56%), Grafton County (58%) and Carroll County (44%). Similarly, Cigna's overall market share is 19%, but it does more work in Cheshire County (22%), Hillsborough County (21%) and Merrimack County (21%) than the northern counties.

Analyzing Carrier Competition

One measure used to identify the level of competitiveness in the health insurance market is the Herfindahl-Hirschman Index (HHI), which uses each carrier's market share to calculate overall competitiveness of the market. HHI scores below 1,500 indicate a non-concentrated market, 1,500-2,500 show moderate concentration, and scores higher than 2,500 indicate the market is highly concentrated in the hands of one or a few carriers.

Herfindahl-Hirschman Index (HHI)⁶⁵

The Herfindahl–Hirschman Index (HHI) is a commonly accepted measure of market concentration. The Department of Justice and the Federal Trade Commission use the HHI, among other measures, to analyze mergers and acquisitions involving actual or potential competitors under the federal antitrust laws.

See **Appendix D** for a more detailed explanation of the method and data used to calculate the HHI scores.

The Kaiser Family Foundation (KFF) calculated HHI scores nationally for the Small Group and Non-group markets. KFF found that in 2010 most states' Small Group and Non-group markets were not competitive; in the Small Group market, a total of 39 states had HHI scores over 2,500, while for the Non-group market, 45 states had HHI scores greater than 2,500.⁶⁶

The project team calculated HHI score for carriers using 2011 NHCHIS data on Group size.⁶⁷ This analysis demonstrated varied levels of competitiveness for each Group market:

- In the Large Group market, New Hampshire's score of 2,541 is slightly over the 2,500 upper limit for moderate concentration.
- In the Small Group market, the HHI is 4,015, also showing a highly concentrated market. New Hampshire's score was higher than Kaiser Family Foundation's national median HHI of 3,595 for this market segment, indicating that New Hampshire's Small Group market is less competitive than the national average.⁶⁸
- In New Hampshire's Non-group market, which is less than 5% of the total insurance market in the state, the HHI was 6,054, indicating that this market is not competitive.

HHI scores for each county, using percent membership to represent market share, also showed the carrier market is not competitive. See **Figure 3.11**. Only Rockingham and Hillsborough Counties in southern New Hampshire had HHI scores that showed moderate concentration, while the remaining counties had highly-concentrated markets.

Figure 3.11: HHI Scores for Carriers by County

County	HHI score
Rockingham County	2,138
Hillsborough County	2,315
Strafford County	2,531
Cheshire County	2,586
Carroll County	2,765
Belknap County	2,840
Merrimack County	3,148
Sullivan County	3,390
Coos County	3,739
Grafton County	3,830

>1,500 = moderately concentrated

>2,500 = highly concentrated

⁶⁵ From Department of Justice materials found at <http://www.justice.gov/atr/public/guidelines/hhi.html> and <http://www.justice.gov/atr/public/guidelines/hmg-2010.html#5c>.

⁶⁶ Kaiser Family Foundation, *Focus on Health Reform: How Competitive are State Insurance Markets?*, October 2011, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf>.

⁶⁷ See Glossary for a definition of Group sizes

⁶⁸ Kaiser Family Foundation, *Focus on Health Reform: How Competitive are State Insurance Markets?*, October 2011, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf>.

Stakeholder Viewpoints on Hospital Competition

All stakeholder groups recognized that due to the state’s geography, there is little competition among New Hampshire hospitals. A stakeholder said hospital “competitiveness for providers is local.” The exceptions are in Manchester and Nashua, referred to as hospital towns, where hospitals compete for patients in their catchment area. One seacoast area hospital executive interviewed described the population living on the seacoast as being loyal to their own hospital. In addition, one carrier described Nashua providers as being “threatened by the Massachusetts market.”

One provider described a “series of micro-markets made up of a hospital and the surrounding medical community that has developed over time.”

A unique dynamic of New Hampshire geography is that it is more difficult for residents of southern New Hampshire to access Mary Hitchcock Memorial Hospital, the only tertiary hospital in the state, than Massachusetts General Hospital in Boston.

Southern New Hampshire hospital providers and two of the carriers mentioned the increasing presence of Massachusetts-based providers such as Boston Children’s Hospital, Lahey Clinic, and Massachusetts General Hospital in New Hampshire, as well as other Massachusetts facilities closer to the New Hampshire border.

One hospital executive described “competing and collaborating at the same time” with other hospitals who, due to a small physician pool in the North Country, share hospitalists and call coverage while still competing for patients. This relationship was echoed in comments by other hospitals and the FQHCs.

Another example of hospital collaboration mentioned by interviewees is the Granite Healthcare Network, popularly called the G5, a consortium of five hospitals who are working together to build capacity for information analysis and sharing and improved population health management.

Some carriers felt that hospital purchases of physician practices reduced competition among providers and gave hospitals more power during contract negotiations. A carrier interviewed said “Consumers and providers have no awareness of price variance among providers.”

However, most providers interviewed said they feel powerless when it comes to negotiations with health plans. Several providers, both hospitals and federally qualified health centers (FQHCs)⁶⁹ named Anthem specifically as the dominant force, using phrases such as “the big blue gorilla” and “the 800 pound gorilla”. Providers believe health plans do not consider them a partner in the health care system. While many providers want the state to equalize the power dynamic for contract negotiations with carriers, none offered specific remedies for how this should be accomplished.

⁶⁹ A federally qualified health center (FQHC) is defined by the Medicare and Medicaid statutes and receives federal grants under Section 330 of the Public Health Service Act; FQHC Look-Alikes meet all of the PHS Section 330 eligibility requirements but do not receive grant funding. More information is available at: <http://www.raconline.org/topics/federally-qualified-health-centers/faqs/>

The purchasers interviewed do not see competitiveness among providers; rather, they observe consolidation and collaboration.

What We Can Learn from Data on Hospital Competition

According to 2011 NHCHIS data, the largest market share belongs to Mary Hitchcock Hospital, part of the extensive Dartmouth-Hitchcock health care system, a network of more than 900 primary and specialty care physicians in New Hampshire and Vermont. See **Figure 3.12** for the total charges for each hospital.

Figure 3.12: Hospitals by Percent of Total Charges

Hospital	Total Charges (in millions)	% of Charges
Mary Hitchcock Memorial Hospital	\$244M	15%
Concord Hospital	\$178M	11%
Elliot Hospital	\$177M	11%
Catholic Medical Center	\$165M	10%
St. Joseph Hospital	\$105M	6%
Wentworth-Douglass Hospital	\$105M	6%
Portsmouth Regional Hospital	\$96M	6%
Southern New Hampshire Medical Center	\$91M	6%
Exeter Hospital	\$77M	5%
Lakes Region General Hospital	\$63M	4%
Parkland Medical Center	\$50M	3%
Frisbie Memorial Hospital	\$42M	3%
The Cheshire Medical Center	\$38M	2%
Monadnock Community Hospital	\$27M	2%
Littleton Regional Hospital	\$20M	1%
New London Hospital	\$17M	1%
Androscoggin Valley Hospital	\$17M	1%
Speare Memorial Hospital	\$16M	1%
The Memorial Hospital	\$16M	1%
Alice Peck Day Memorial Hospital	\$14M	1%
Huggins Hospital	\$13M	1%
Valley Regional Hospital	\$12M	1%
Franklin Regional Hospital	\$10M	1%
Weeks Medical Center	\$9M	1%
Northeast Rehabilitation Hospital	\$7M	< 1%
Cottage Hospital	\$5M	< 1%
Hampstead Hospital	\$3M	< 1%
Upper Connecticut Valley Hospital	\$3M	< 1%
HealthSouth Rehabilitation Hospital	\$2M	< 1%
New Hampshire Hospital	\$1M	< 1%
Total	\$1,620M	100%

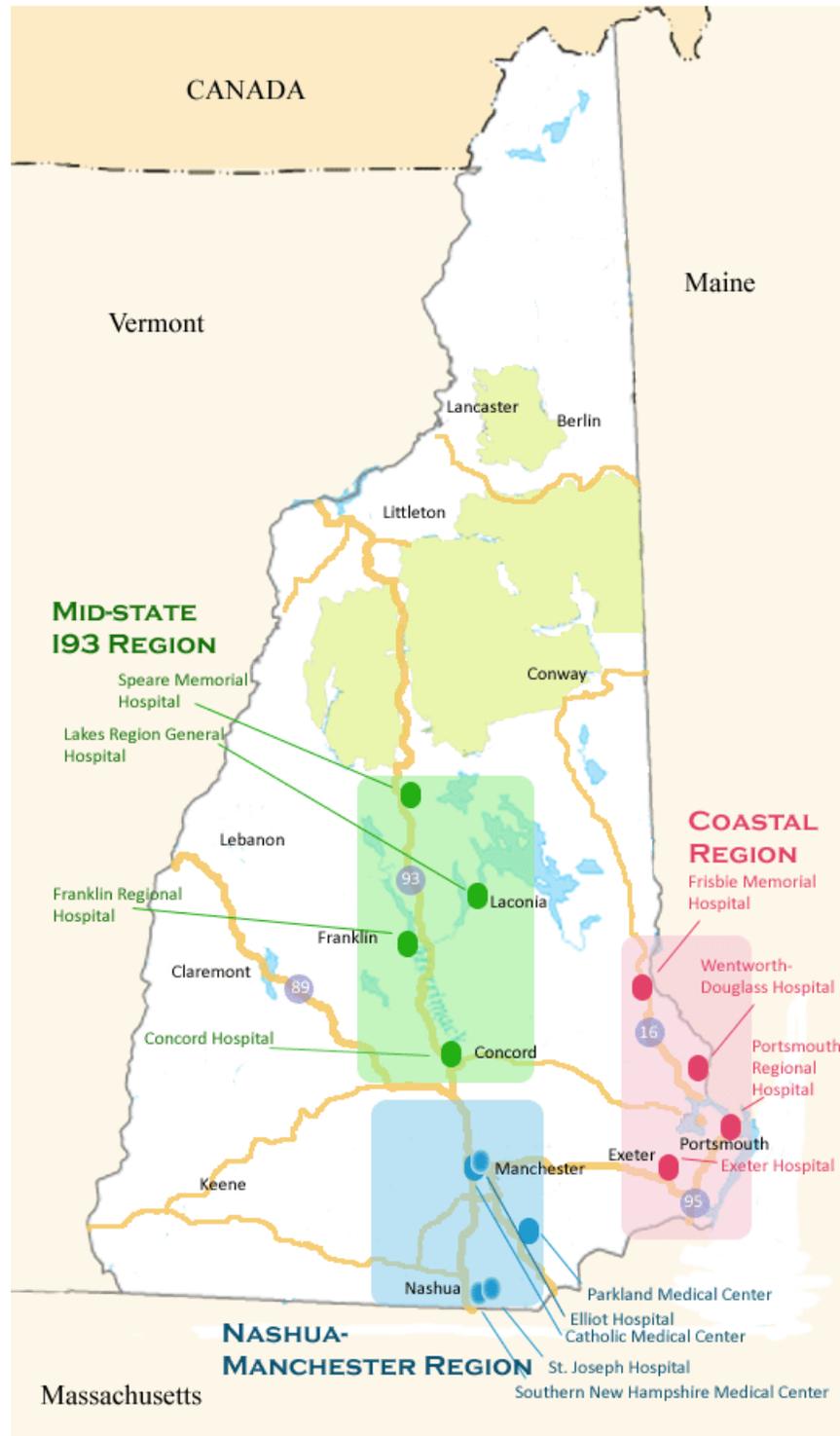
Source: Authors' analysis of 2011 NHCHIS

As stakeholders mentioned, in some regions of New Hampshire there is little competition among hospitals. Due to their isolated locations, the six northern hospitals face limited competition. Also, specialty hospitals often do not face competition and thus command more power in the marketplace.

However, in three regions, multiple acute care hospitals compete for market share: along I93 mid-state, along the coastal region, and in the Nashua-Manchester area (see **Figure 3.13**).

The project team calculated HHI scores based on total payments for each acute hospital in those three regions, but did not include specialty hospitals sited in those geographic regions. In addition, the project team did not calculate an HHI score for isolated hospitals without competitors. See **Appendix D** for more information on calculating and interpreting the HHI score.

Figure 3.13: Map of Three Potentially Competitive Hospital Markets



The HHI calculations shown in **Figure 3.14** indicate that the mid-state I93 region, with an HHI score of 4,783, is highly concentrated. The Coastal region, with a score of 2,675, also has a highly concentrated market, albeit it less so than the I93 region, due to three Coastal hospitals all having large market shares. But the Nashua-Manchester region has a score of 2,396, which indicates only moderate concentration;

four hospitals each have large market shares. Note that Concord Hospital could be included in either the Mid-state I93 region or the Nashua-Manchester region without changing the level of competitiveness in those regions; if Concord is excluded from the I93 region, the region’s HHI score would still show a highly concentrated market, while inclusion of Concord in the Nashua-Manchester region would lower that region’s HHI score but it would still show moderate concentration. In addition, if Massachusetts border hospitals were included in the analysis, the market concentration for southern New Hampshire hospitals would likely decrease.

Figure 3.14: HHI scores to evaluate hospital competitiveness in three regions

Mid-state I93 region	% of payments
Speare Memorial Hospital	7%
Lakes Region General Hospital	25%
Franklin Regional Hospital	5%
Concord Hospital	64%
HHI score:	4,783
Coastal region	% of payments
Frisbie Memorial Hospital	14%
Wentworth-Douglass Hospital	31%
Portsmouth Regional Hospital	27%
Exeter Hospital	28%
HHI score:	2,675
Nashua-Manchester region	% of payments
St. Joseph Hospital	17%
Southern New Hampshire Medical Center	16%
Parkland Medical Center	8%
Elliot Hospital	34%
Catholic Medical Center	25%
HHI score:	2,396

Source: Authors’ analysis of 2011 NHCHIS

Stakeholder Viewpoints on Physician Competition

Many providers interviewed concurred that the physician market is not competitive due to two issues: geography and consolidation. Rural regions lack sufficient numbers of physicians to create competition. In addition, multiple carrier and provider stakeholders mentioned the recent trend of hospitals purchasing physician practices, reducing competition. One FQHC mentioned the use of loan forgiveness as an incentive to bring providers to rural areas. Purchasers concurred that there is limited competitiveness among physicians. With more primary care physicians becoming hospital employees, many providers see a shift in power from independent practitioners to the hospital.

Carriers interviewed agreed there is little competition among physicians, and they find it difficult to negotiate competitive rates among physicians that have developed geographic monopolies. Carriers mentioned more physician competition in cities such as Nashua and Manchester, as well as the threat from Massachusetts physicians to attract patients living in southern New Hampshire. Specialists,

especially those in the geographically isolated sections of the state, generally do not negotiate with carriers because the specialists believe they lack competitors. One hospital said it takes them a year or more to recruit specialists.

One carrier representative stated “very few outpatient services are not owned by the hospital systems.”

Stakeholders across groups raised a number of concerns about the merging of physician organizations via hospital acquisition of physician practices. First, stakeholders are concerned that merged entities are demanding higher fees. They also attributed premium rate increases to the practice of including a facility fee or other hospital charge when billing for outpatient services; costs would be lower if the hospital and physician groups contracted separately. Lastly, stakeholders said that merged entities increased their market power through consolidation and thus avoided pressure to contain cost increases. One provider interviewed said that consolidation creates an organization with more resources to invest in infrastructure to improve quality, but “the jury is still out as to whether the growing organizations will use this for clout or for achieving better results.”

What We Can Learn from Data on Physician Competition

Health industry stakeholders agree there is a lack of provider competition, in particularly in the North Country. However, county health rankings from the Robert Wood Johnson Foundation show fewer residents per primary care physicians in Grafton and Coos Counties in the north, only then followed by the more populous Hillsborough County.⁷⁰ See **Figure 3.15**.

Figure 3.15: Number of Residents Per Primary Care Physician (PCP)

NH Counties	# of residents per PCP
Grafton County	530
Coos County	804
Merrimack County	861
Hillsborough County	1,201
Rockingham County	1,257
Strafford County	1,354
Carroll County	1,407
Cheshire County	1,454
Belknap County	1,502
Sullivan County	1,508
State	1,102
National average	2,596

⁷⁰ Robert Wood Johnson Foundation, *County Health Rankings and Roadmaps*, <http://www.countyhealthrankings.org/app/new-hampshire/2013/coos/county/outcomes/overall/snapshot/by-rank> (June 2013).

C: Plan Design

Health plans use plan design as a method to control costs and improve quality of care. Employers have the option of self-insuring their health care coverage, which means assuming financial risk for employee health care costs rather than purchasing a fully-insured product from a carrier. Self-insured employers can then attempt to control costs through greater flexibility in the types of products offered and creative solutions to insurance challenges. All employers face choices regarding how much to increase employee cost sharing in order to reduce premiums. Carriers design an array of products to give purchasers the option of higher-cost products with more choice of providers (as in a PPO) versus products with lower rates of cost-sharing and a more limited choice of providers (as in an HMO). Plan design can include approaches such as:

- site of service—the use of incentives to steer patients to lower cost independent laboratories and other facilities to remove the high cost of hospital overhead
- limited networks or tiers—limiting access to providers to reduce costs, through better contracting with in-network providers and/or by imposing higher costs on consumers for their use of non-preferred or out-of-network providers

Stakeholder Viewpoints on Plan Design

Employers said they are interested in innovative products and plan designs that lower costs. A stakeholder said 45% of firms are self-insured. Stakeholders identified as key drivers of system transformation both employer choice to self-fund company insurance plans, as well as new plan designs that attempt to control health care costs. Employers say plan designs with a site of service component and increased cost sharing for employees are the only successful levers to protect them from rising health care costs and enable them to continue providing health insurance coverage for employees and their families.

For employers, moving to a self-funded plan provides more flexibility in developing cost-containment solutions through benefit design, such as incentives to use lower-cost providers, as long as their Third-Party Administrator (TPA) can configure their systems to support the desired benefit design. A second advantage to being self-funded is less federal and state regulation of product offerings and coverage. In addition, both purchasers interviewed for this analysis have invested in their employees' wellness with the firm belief that healthier populations will ultimately use fewer services and drive costs lower. Also, both firms have implemented free on-site access to primary care, in collaboration with their local health system. For these employers, their size and the geographic distribution of their employee population makes this model more feasible than it might be for smaller or more geographically dispersed firms.

However, providers expressed concern that the market may not benefit from a shift of employers to self-funding because it removes people from the commercial insured risk pool and could have a negative downstream impact. Providers fear that as more of the larger employers move to self-insurance, the fully insured pool will become smaller and more expensive; this trend will drive additional business to change to self-insured plans, leaving the fully insured system for non-group members, small businesses, and large businesses with high risk. The result would be increased premiums in the fully insured market and a larger variance between self-insured and fully insured premiums, which currently differ by only 3%. There are additional impacts on public health; for example, the state's free vaccine program is funded by fully insured commercial carriers, but since the pool is no longer sufficient to cover the cost of the program, alternative funding for this program may be required in the future.

The two Federally Qualified Health Centers (FQHC) and one FQHC Look-Alike interviewed, as well as the professional association for primary care practices, all agree plan design should focus on primary care and care integration to both improve quality and reduce costs. They see a focus on population health as

having the most potential for eventually reducing the amount of care needed, and therefore the total cost of care. The primary care practices, as well as one employer interviewed, also expressed concern that increased cost-sharing via higher deductibles and co-payments deters patients from seeking care, filling their medications, and getting needed procedures. Costs increase for the system when patients delay treatment until their health situation is critical, and thus more expensive to treat.

One provider said the state needs to “invest in primary care” and that “demand will increase with the expansion of the insured through the Exchange and Medicaid expansion.”

Some carriers have been using tiering as a method to mitigate costs. These products include higher cost-sharing amounts for patients when they select providers deemed more expensive or with lower quality scores. Most stakeholders, including carriers, were not in favor of provider tiering as a strategy to improve care and reduce costs. Interviewees mentioned that tiering of providers is challenging in parts of New Hampshire where the choice of provider is limited by geography; placing the sole hospital in a region into a less-favorable tier would not be fair to patients who live in that hospital’s area. In other cases, tiering may not be successful due to the patient loyalty to local community hospitals even when choice is an option.

Stakeholder Viewpoints on Site of Service

Stakeholders from all sectors agreed carriers have successfully implemented site of service plan design in the Small Group market as a strategy to reduce costs, by steering patients to use lower-cost free-standing, independent laboratories and out-patient surgical centers rather than services at hospitals. These plan designs provide an incentive to patients to use lower-cost providers by affecting their cost share. For example, a plan design may not count a lab test toward the member deductible if the lower-cost (site of service) provider is used, but will charge the deductible if the member gets care at a hospital or other higher-cost provider.

Carriers acknowledged the need to incorporate some site of service facilities into their products in order to remain competitive with carriers such as Anthem, which includes site of service as a large part of their Small Group plan design.

However, both hospitals as well as some carriers spoke against site of service plans, saying they drain financial resources from hospitals. Providers also mentioned concerns with the quality of services at site of service facilities. One hospital executive said they “don’t see the result of the lab draw or pathology reports” when the lab used was off campus from the hospital; this resulted in delayed treatment for the patients. Many providers, both hospitals and FQHCs, expressed concern that plan designs that increase patient cost share and/or steer patients to low-cost providers are resulting in fragmented care.

What We Can Learn from Data on Plan Design

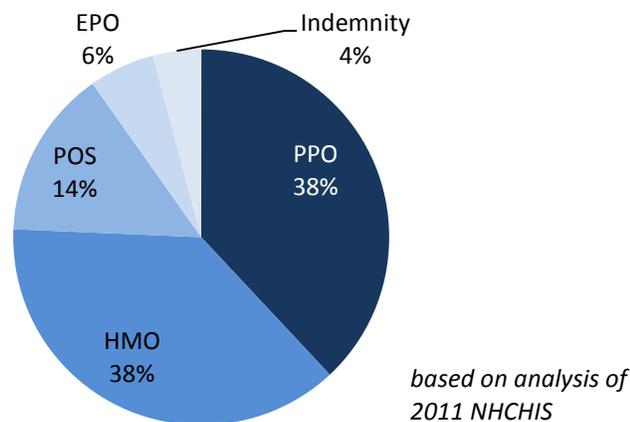
Consumers express desire for the conflicting goals of lower-costs and a larger choice of providers. Products that offer more freedom of choice also often have higher visit costs (co-payments, co-insurance and deductibles) and/or premium costs. For each product, carriers offer a different balance between choice of providers and consumer costs in the form of premium levels and cost-sharing structure. Indemnity plans allow members the greatest flexibility in selecting their providers, but they often have

higher costs. PPO and POS plans require higher cost sharing for out-of-network providers. Finally, HMOs restrict members to network providers, but often have lower premiums and cost-sharing.

PPOs and HMOs are the largest product types in the New Hampshire insurance market, each comprising 38% of the market. However, given that the data are from 2011, more recent trends and movement between products are not reflected in these figures.

Nationally, 16% of workers were enrolled in an HMO, 56% in a PPO, and 9% in a POS plan in 2012; note, these figures do not include the 19% workers enrolled in high deductible health plans with savings options.⁷¹ See **Figure 3.16** for the number of members in each product type in New Hampshire.

Figure 3.16: 2011 New Hampshire Market Share by Product Type



The types of products offered can vary for the self-insured and fully insured markets. According to NHCHIS data, 58% of covered employees are in self-insured plans and 41% are in fully insured plans statewide,⁷² consistent with consumer opinion on the matter stated during the interview process.

- Among fully insured plans, over half of the Large Group and Small Group members are enrolled in HMOs (56% and 69% respectively), with the next largest segment being PPOs (28% and 16% respectively).
- Among self-insured plans in the Large Group market, there is greater diversity among plan types, with 42% of members enrolled in PPOs, 25% in HMOs, and 23% in POS products.
- However, in the self-insured Small Group market, 92% of members are enrolled in PPOs.
- Similarly, 95% of fully-insured Non-Group members are enrolled in a PPO product.

See **Figure 7.1** in **Appendix E** for a detailed breakdown of plan type for the fully insured and self-insured markets.

⁷¹ Kaiser Family Fund and Health Research and Education Trust, *Employer-Sponsored Health Coverage, March 2013*, <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/2012-employer-health-benefits-chart-pack-private-insurance-091112.pdf>.

⁷² Source: Authors' analysis of 2011 NHCHIS.

What We Can Learn from Data about Tiering and Networks

Through the survey of 2011 carrier data, the project team asked for data on the use of tiers as well as the use of limited networks. Both of these approaches are efforts to control costs. Three carriers completed the survey, representing approximately two-thirds of the marketplace. The project team aggregated the data from their responses.

Carrier Survey Definitions:

Limited network products: The member is covered for care received at participating network providers, but out-of-network non-emergency care is not covered.

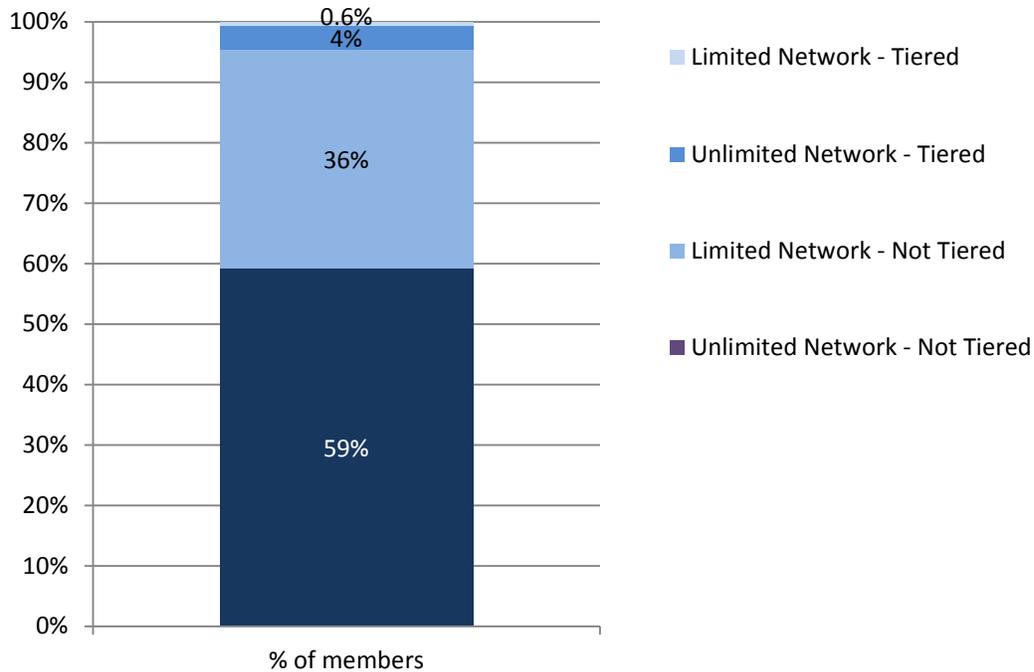
Unlimited network products: The member is covered for care received at network and non-network providers. This includes products that require higher patient cost sharing for out-of-network care.

Tiered: The carrier assigns hospitals or physician practices to different tier levels based on a defined set of quality, cost, or utilization metrics. Patients incur varying levels of cost-sharing based on the tier of the provider from which they receive care. For the purposes of this survey, a product that tiers only prescription drugs was not reported as a tiered product.

Not tiered: The carrier does not vary patient cost-sharing based on tiers of hospitals or physician practices. Any product that only varies cost-sharing based on tiers of prescription drugs was included as *Not Tiered*.

Limited networks are used as a cost savings method, since carriers can contract with network providers at lower rates. As **Figure 3.17** shows, the majority of members are in unlimited networks, while only approximately 37% of members are in limited networks.

Figure 3.17: Percent of members by network type, 3 large carriers



Source: Authors' survey of 3 large carriers' 2011 data

Only 5% of members are in tiered networks, while 95% are in networks that are not tiered. In addition, the carriers were less likely to use quality metrics than cost metrics in their tiering programs. See **Figure 7.2** in **Appendix E** for details on the metrics carriers use. These results support stakeholder comments made during the interviews.

D: Delivery and Payment System Reform

Another approach to reducing costs and improving quality involves more extensive delivery and payment system reform efforts. This approach includes holding providers accountable for their patients' health and use of medical services, through development of ACOs and risk-bearing contracts that reward providers for patient outcomes, as well as by redesigning the care delivery system to be more patient-centered and focused on wellness. These efforts are expected to reduce costs through lower utilization of high cost procedures and hospital inpatient services.

New Hampshire's health care industry faces the same challenge that exists nationwide, as the current payment mechanisms lack the ability to cover non-traditional payment arrangements.

Stakeholder Viewpoints on Delivery System Redesign

At least one person in each stakeholder category, and most participants overall, noted that coordination of care and accountability for management of populations of patients is the right approach to achieving a high value health care system in New Hampshire. One provider said the "provider community is positioning themselves to move in the direction of more patient-centered, coordinated care." Models such as Patient Centered Medical Homes (PCMHs), Accountable Care Organizations, and Centers for Medicare and Medicaid Services (CMS) Shared Savings models support this approach. A carrier said "New Hampshire is advanced in PCMHs" with many Level 3 NCQA accredited.

There are several extant examples of provider initiatives to integrate and coordinate care, including the Dartmouth ACO, the North Country ACO and the Granite Healthcare Network (G5 hospital consortium). Further, the Citizens' Health Initiative and the New Hampshire Purchasers' Group on Health continue to support and move forward collaborative models between providers, carriers and purchasers to 'test out' new payment and delivery system models in an effort to improve quality and address high costs. An employer interviewed said they are "partnering with Dartmouth-Hitchcock, putting a dashboard together on wellness measures" as a way to reduce costs through improved health of employees. Another stakeholder said "MCOs [Managed Care Organizations] can provide great value to the health centers because of their robust informatics."

"Value-based discussions have gained a lot of steam in New Hampshire," said one stakeholder.

For example, the Granite Healthcare Network purchased Verisk, a software tool that helps with population health management, for use in its five hospitals. Second, providers are eager to create new opportunities to experiment with innovative models of care and to take on risk. For example, a group of community health centers established the North Country ACO in order to take advantage of a Medicare shared savings pilot, whereby providers receive part of the savings for meeting care benchmarks at reduced costs.

A number of providers expressed interested in taking on risk,⁷³ though one hospital was not interested because they do not have the infrastructure or skills needed to manage population health. Independent

⁷³ Employer financial risk for costs of health coverage for employees—that is, whether the employer wants to risk owing addition funds if employees' health care costs rise or would prefer to let an insurance carrier assume that risk—is different from provider financial risk—which involves holding providers financially accountable for poor patient outcomes or patient cost of care.

primary care practices, most often FQHCs, Rural Health Centers, or FQHC Look-Alikes understand the need for care reform and are practicing a model of care that aligns with ACA models and brings value to the system. One Critical Access Hospital said they are part of Dartmouth-Hitchcock's ACO, and the "motivation is to reduce costs"; the stakeholder explained the ACO has both upside and downside risk in its contract with Anthem. Several stakeholders indicated they were waiting to see the outcomes of a national three-year study the Centers for Medicare and Medicaid Services (CMS) is conducting of four models of bundled payments for inpatient acute care and post-discharge services. A provider commented that it is "going to be a wild ride," and they will need to "look for opportunities that are appropriate."

Interviewees expressed both an interest in health system transformation, as well as reservations regarding the ability to do so. Some expressed doubts about provider willingness to accept risk and the inability of the current claims system to support change; one provider said "Bundled payments are bigger than a breadbox. Claims systems aren't ready and providers aren't in agreement clinically on what should be included." In addition, one carrier said to "be careful of ACOs", and that they "should be building integration versus gaining leverage through size." Another stakeholder said "[We're] not seeing the integration you would expect either clinically or administratively, even for many of those that are formally integrated," adding that they do not see providers and patients interested in "changing the way health care is delivered," such as patient centered medical homes. Another provider said they are not seeing pay-for-performance, global payments or other alternative payment methods, and a carrier said they use "very few bundled or fixed payment methods (such as DRGs or per diems)" and that "percent of billed charges is still predominately used."

A carrier noted that "When there is no progress on new models, it's because infrastructure is lacking."

In order to continue to move the system toward value, stakeholders feel they need:

- Appropriate funding for technology and workforce development
- Skills and technical ability within and across providers
- Capacity to utilize actionable population and performance management reporting data
- Ability to develop interventions or responses to address gaps in care

However, carriers feel that despite a fair amount of consolidation among providers, there is a lack of clinical and administrative integration. Carriers also mentioned that alternative provider entrants to market, such as Shields and CVS MinuteClinic, are not interested in the New Hampshire market due to the small size and the difficulty in obtaining provider referrals and encouraging patients to move away from the existing delivery system.

Many stakeholders expressed concerns about system changes related to the Affordable Care Act, such as the imminent implementation of the Health Benefit Exchange and possible Medicaid expansion, worrying that these changes could result in physician shortages and further underpayment by an expanded Medicaid program.

Finally, stakeholders expressed other opinions on large-scale reforms to the health care industry. One interviewee observed, "Strategically, health insurance is no longer an employment differentiator. Employer as purchaser may not be the model in the future."

Stakeholder Viewpoints on Mental Health and Substance Abuse Services

Multiple stakeholders said New Hampshire’s current health care system inadequately supports the needs of its citizens faced with mental health and substance abuse challenges. Specifically, the state reduced Medicaid funding for badly-needed substance abuse services. Further, there is an insufficient number of inpatient beds for mental health. More than one stakeholder mentioned a recent experience with a patient waiting in an emergency room for several days before a mental health bed was available. More than one stakeholder used the phrase ‘crisis’ to describe the current situation regarding inpatient mental health.

What We Can Learn from Data about Mental Health and Substance Abuse Services

According to the New Hampshire Chapter of the National Alliance on Mental Illness (NAMI), patients may wait in the emergency department for one or more days until a bed becomes available.⁷⁴ In December 2012, the Department of Health and Human Services recognized the issue of psychiatric patients being held in emergency rooms due to a lack of available mental health beds. Commissioner Nicholas Toumpas said the administration would propose to address funding needs in the upcoming budget, including funding for New Hampshire’s 10-year plan for addressing the mental health needs of New Hampshire residents. One priority identified in the plan is for the state to help people with mental health issues live in their communities with the supports they need.⁷⁵

In addition to decreased state funding for mental health and substance abuse services, coverage by carriers for these services decreased for all members from 77% to 74% between 2010 and 2011.⁷⁶ As **Figure 3.18** shows, the employees working for large employers—who are more likely to be in Self-insured and Large Group plans—saw a reduction in coverage for mental health and substance abuse services.

Figure 3.18: Percent of members covered for mental health and substance abuse services

	2010	2011
All members	77%	74%
Self-insured	67%	62%
Fully insured	88%	89%
Large Group	72%	68%
Small Group	98%	99%
Non-group	81%	87%

Source: NHID, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*

Stakeholder Viewpoints on Certificate of Need

Stakeholders frequently mentioned the Health Services Planning and Review Board’s (HSPR Board) Certificate of Need (CoN) process, whereby the HSPR Board reviews and approves construction of new or expanded health facilities. One carrier said the CoN process “costs a ton of money” and that the

⁷⁴ New Hampshire Chapter of the National Alliance on Mental Illness, *Press Conference, RE: People in a Mental Health Crisis Being Held in Emergency Departments Waiting for an Inpatient Bed*, January 2013, <http://www.naminh.org/sites/default/files/EDwaitingsummary6.pdf>.

⁷⁵ New Hampshire Department of Health and Human Services, Press Release, *DHHS Releases Plan to Reduce Wait Times for Patients Seeking Inpatient Psychiatric Care*, December 2012, <http://www.dhhs.state.nh.us/media/pr/2012/12112012psycare.htm>.

⁷⁶ New Hampshire Insurance Department, *Supplemental Report of the 2011 Health Insurance Market in New Hampshire*, February 2013, http://www.nh.gov/insurance/reports/documents/2011_nhid_suprpt.pdf and New Hampshire Insurance Department, *Supplemental Report of the 2010 Health Insurance Market in New Hampshire*, April 2012, http://www.nh.gov/insurance/lah/documents/sup-rep_10.pdf.

“committee is powerless”. Stakeholders all agree the state should review and potentially restructure the Certificate of Need process, in order to align the process with state goals. Many stakeholders—both carriers and providers—feel the current Certificate of Need process is flawed, as the Board “rubberstamps” approval of new facilities and allows the construction of unnecessary new facilities that hurt hospitals financially. One interviewee said the “state has responsibility to protect ‘charitable trusts’ from cherry pickers – we can’t afford to see hospitals fail.” A provider questioned whether the increased competition through the construction of additional facilities will drive down cost, yet also wondered whether these new facilities will maintain quality standards. The common message stakeholders expressed is that New Hampshire should have a vision for healthcare, which the CoN process would then support.

What We Can Learn from Data on Delivery System Redesign

Delivery system redesign is underway in New Hampshire, through collaborations that attempt to reshape the relationship between patients, providers, and carriers. Accountable Care Organizations as well as looser affiliations and consortiums are common among physicians and hospitals. Through combined resources and performance-based contracts, these collaborations aim to improve the efficiency and effectiveness of the care they provide. Citizen-based initiatives work with consumers to improve population wellness, and with employers and providers to test out new models of care.

Below are some examples of payment and care reform initiatives currently underway in New Hampshire; if these initiatives are successful, they may serve as models for state efforts to improve the quality and decrease the cost of health care. **Figure 3.19** is a map of New Hampshire indicating the location of the organizations involved in these innovation initiatives.

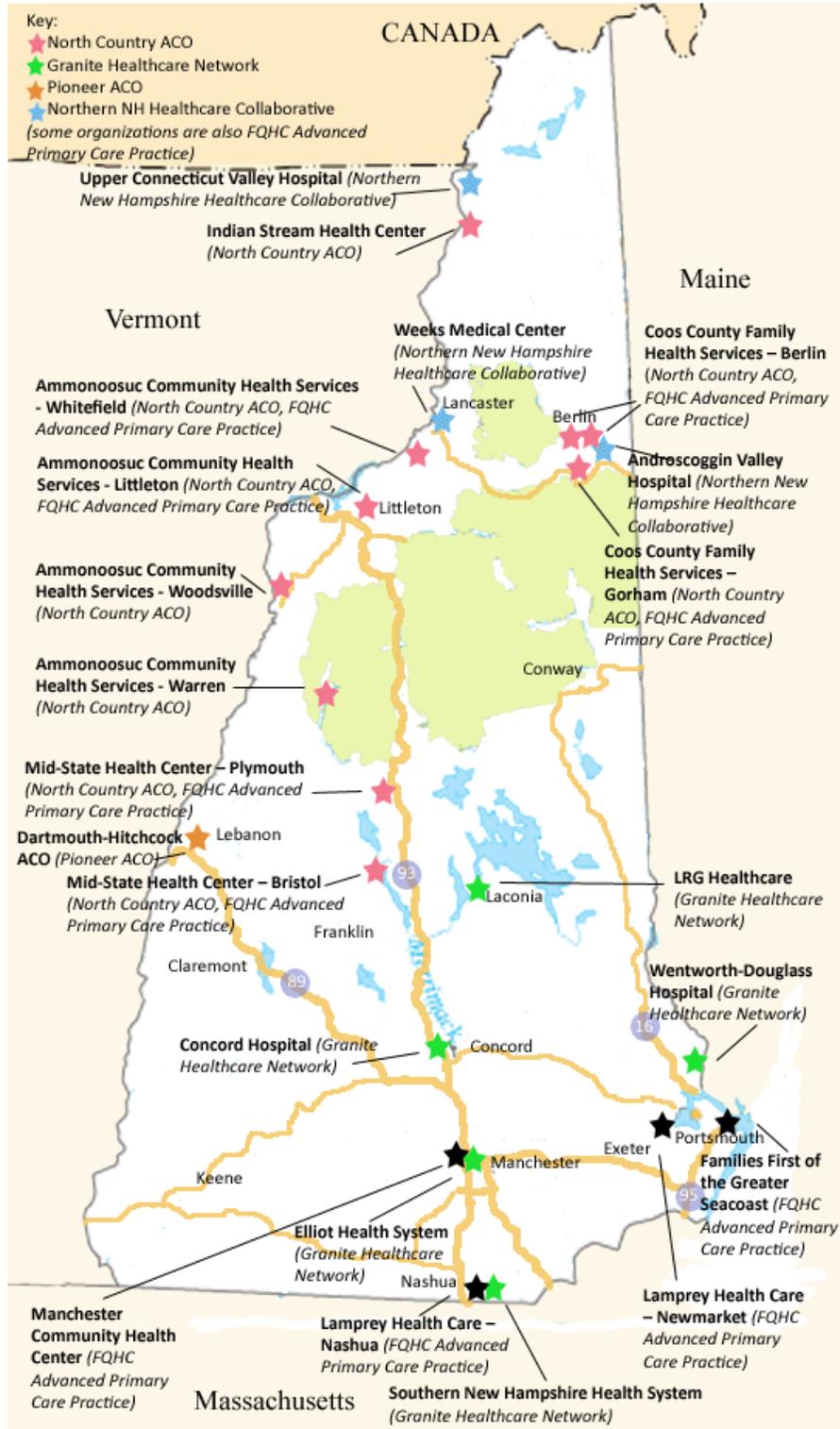
CMS Demonstrations and Pilots

There are currently a number of payment and care reform demonstrations and pilots funded by the Centers for Medicare and Medicaid Services (CMS) in which various New Hampshire providers are participating. The individuals and organizations involved in these projects can share lessons learned to assist peers in their care reform efforts.

- **State Innovation Models Initiative:** To align consumer access across delivery system silos, carrier support for outcomes-based long-term care services, and global accountability for cost-effectiveness and outcomes. Participating entities: statewide
- **Pioneer ACO Model:** To allow provider groups to move from a shared savings payment model to a population-based payment model on a track consistent with the Medicare Shared Services Program, by working with private carriers to align provider incentives to improve quality and outcomes as well as achieve savings for Medicare, employers and patients. Participating entities: Dartmouth-Hitchcock ACO
- **Advanced Payment ACO Model:** To enable physician-based and rural providers who have voluntarily created an ACO to coordinate high-quality care for Medicare patients. Participating entities: North Country ACO
- **Medicaid Incentives for the Prevention of Chronic Diseases Model:** To provide incentives to Medicaid beneficiaries who participate in prevention programs and demonstrate changes in health risks and outcomes, using evidence-based research. Participating entities: state-wide
- **FQHC Advanced Primary Care Practice:** To show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs. Participating entities: Ammonoosuc Community Health Services (Littleton and Whitefield), Coos County Family Health Services (Gorham, Page Hill, Pleasant), Families First of the Greater Seacoast, Lamprey Health Care

(Nashua, Newmarket), Manchester Community Health Center, Mid-State Health Center (Bristol and Plymouth))

Figure 3.19: Map of Innovation Initiatives in New Hampshire



Additional Examples of Innovation in New Hampshire

Several notable examples of health care reform demonstrate the feasibility of accountable, high-value and reduced cost care in New Hampshire. These trend-setting hospitals, physician groups, employers and community groups have created affiliations to improve services and lower costs. Since many of these efforts are new, there is often insufficient data on their effectiveness. However, one carrier said the ACO they contract with reduced emergency room visits, hospital readmissions, and specialist visits in the first year.

- **New Hampshire Citizens Health Initiative: Accountable Care Project**
The Initiative is a collaboration between providers, employers and community agencies to develop a high-quality, cost-effective system of care for all citizens. Currently The Initiative focuses on health promotion and disease prevention, payment reform, and patient medical homes. In 2010, they launched a five year ACO pilot providing care for 400,000 residents through 700 providers; using health analytics, The Initiative will be reporting on cost, quality and utilization to support system transformation.
- **New Hampshire Purchasers' Group on Health (NHPGH)**
A collaboration of the state's four largest public health care purchasers, NHPGH aims to increase the transparency of health care costs in the state to positively affect medical cost inflation and to make available information about the quality of healthcare services and the providers of those services.
- **North Country Accountable Care Organization**
The North Country ACO is a collaboration between four rural community health centers, Ammonoosuc Community Health Services, Coos County Family Health Services, Mid-State Health Center, and Indian Stream Health Center. Together, these organizations share a goal of improving care for Medicare Fee For Service patients, decreasing costs, and increasing efficiency. They work with community partners, including hospitals, mental health centers, and home health agencies, to improve care coordination, patient outcomes, and foster collaboration. As a participant in CMS's Shared Savings program, the ACO must meet benchmarks to qualify for savings, or be held accountable for losses.
- **Granite Healthcare Network (GHN)**
Granite Healthcare Network is a partnership between five independent health care organizations-- Concord Hospital, Elliot Health System, LRGHealthcare, Southern New Hampshire Health System, and Wentworth-Douglass Hospital—to transform health care delivery by sharing resources. GHN focuses on decreasing inappropriate hospital readmissions; improving care to patients with behavioral health issues; using a patient-centered, data driven care management process to improve both clinical care and costs; working with Verisk Health to develop health analytics to inform care; and reducing costs through initiatives such as creating one common reference lab. Four of the five hospitals formed the Granite Shield Insurance Exchange (GSIE), a captive insurer that enables the hospitals to pool risk and reduce their liability insurance costs.
- **Dartmouth-Hitchcock ACO**
Dartmouth-Hitchcock created an ACO to provide a continuum of care for patients and be held accountable for costs and quality of care. The core of the ACO is a patient-centered medical home. Registered nurses became care coordinators who educate patients and interface with clinical care team. Chronic disease patient registries enable staff to identify and monitor care for at-risk patients. Dartmouth-Hitchcock targeted both clinical conditions as well as reduction in costs at various locations. With a goal of 50% global payments in 5 years along with downside risk for select providers, Dartmouth-Hitchcock works with multiple commercial carriers to reform the payment system. Dartmouth-Hitchcock has clinics in both New Hampshire and Vermont.

- **Northern New Hampshire Healthcare Collaborative (NNHHC)**

A partnership between three Coos County hospitals (Upper Connecticut Valley Hospital, Weeks Medical Center, and Androscoggin Valley Hospital), the goal of NNHHC is to provide high quality, outcome-based care for all North Country patients, and control costs through innovative programs and sharing resources. They share specialists, and have worked to improve the transfer of patients between facilities.

“Create a grassroots role for businesses and consumers in health care planning,” a stakeholder said.

What We Can Learn from Data on Payment Reform

During interviews, stakeholders indicated they are actively working on alternative payment methods, such as bundled payments, global payments, and provider risk, and approximately half of the carriers interviewed said they are engaged in pay reform as well. The 2011 data survey shows that payment reform has begun in New Hampshire, with a variety of carriers and ACOs using performance-based payment methods.

The carrier survey sheds some light on the extent payment reform innovation is occurring in New Hampshire, in the form of pay-for-performance contracts and risk-bearing contracts, as well as bundled and global payments. The survey asked carriers to report number of contracts, total payments, and total charges in 2011 for five types of payment methods, defined below, and for five providers types (Accountable Care Organization/Physician Hospital Organization; hospital inpatient; hospital outpatient; physician practices; and other providers). The project team aggregated the data from the three carriers who responded to the survey.

Carrier Survey Definitions

Charge-based payment: Includes contracts in which payments are based on the provider's billed charge, such as a percent of the provider's billed charge, 100% of billed charge, or arrangements in which the carrier limits the billed charge to some maximum (e.g. regional maximum).

- *With Pay-for-Performance:* Includes contracts that are based on a fee schedule, and in which the carrier makes additional payments or imposes payment penalties based on the provider's performance on specific quality, cost, or utilization goals.
- *No Pay-for-Performance:* Includes contracts that are based on a fee schedule, without additional payment or penalty based on performance goals.

Fee Schedule, with pay-for-performance: Include contracts in which payments are based on a standard fee schedule adopted by the carrier. Includes payments based on diagnostic related groups (DRGs), the Ambulatory Patient Classification (APC) model, or other grouping models.

- *With Pay-for-Performance:* Includes contracts that are based on a fee schedule, and in which the carrier makes additional payments or imposes payment penalties based on the provider's performance on specific quality, cost, or utilization goals.
- *No Pay-for-Performance:* Includes contracts that are based on a fee schedule, without additional payment or penalty is made based on performance goals.

Global payment: Include contracts that pay a provider for the total cost of care provided to a specific patient population that has been attributed to that provider. Global payments usually use a per member per month (PMPM) payment. Contracts which use fee-for-service but reconcile to a PMPM amount are also to be included as global payments.

- *No downside risk:* Includes contracts that use a global payment method, but do not place the provider at financial risk. Typically in these cases, the contract will include a hold-harmless provision to ensure that the provider receives the same payment under the global payment method as it would have received using a fee-for-service method. This includes contracts that have shared savings provisions with the provider, without shared loss provisions.
- *With downside risk:* Includes contracts that use a global payment method, but do place the provider at some level of financial risk.

Other: Contracts that use other payment methods that do not meet the categories outlined above.

Bundled payment: Defined as “a single payment is made for an episode of care—a defined set of services delivered by designated providers in specified health care settings, usually delivered within a certain period of time, related to treating a patient's medical condition or performing a major surgical procedure.”⁷⁷ It does not include payments based solely on DRG, APC, or Ambulatory Patient Groups (APGs) as bundled payment.

⁷⁷ Mark Zezza, et al., *The Commonwealth Fund, The Bundled Payment for Care Improvement Initiative: Achieving High-Value Care with a Single Payment*, January 2012, <http://www.commonwealthfund.org/Blog/2012/Jan/Bundled-Payment-for-Care-Improvement.aspx>.

Payment Method

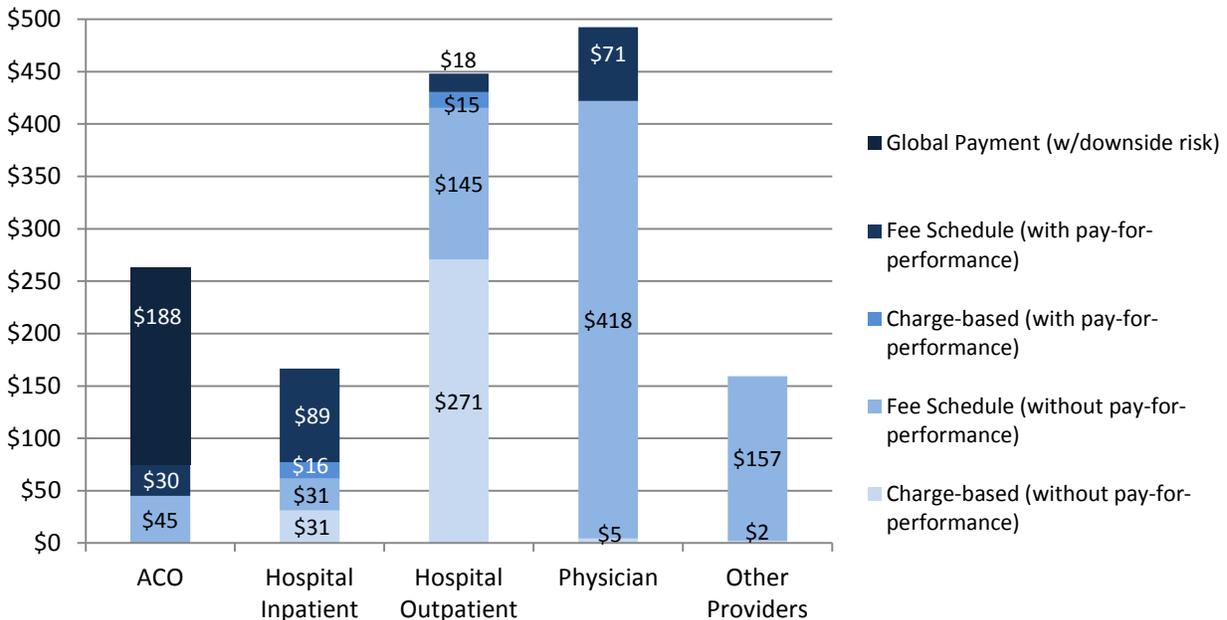
The 2011 data from the carrier survey show that New Hampshire insurance carriers rely primarily on traditional payment methods such as charges or fee-for-service, with only a 12% of payments made using alternative payment methods or pay for performance, such as global or bundled payments. Carriers have global payment arrangements with downside risk in place for ACOs, but not for any other provider type surveyed. Carriers report no payments to any provider types using a global payment with no downside financial risk and only 0.1% of payments using a bundled payment methodology.

According to the three carriers who responded to the survey, ACOs they contract with received 64% of their payments via a global payment arrangement with downside risk; another 10% from contracts that included pay-for-performance provisions; and only 26% from contracts with neither risk-sharing nor pay-for-performance provisions.

Overall, only 20.1% of fee schedule and charge-based payments, such as DRGs or per diem, used pay-for-performance incentives. A total of 50% of hospital inpatient payments were paid using a fee schedule with pay-for-performance. However, only 14% of physician payments included pay-for-performance provisions; nationally, approximately half of medical groups received performance payments from private insurance carriers.⁷⁸

Figure 3.20 shows the total payments made using each payment method. Note that 2012 NHCHIS data, when it becomes available, may show a different use of payment methods.

Figure 3.20: Payment Amount by Payment Method for Each Provider Type
(in millions of dollars)



Source: Authors' survey of 3 large carriers

⁷⁸ James Robinson, et al., The Commonwealth Fund, *Quality-Based Payment for Medical Groups and Individual Physicians*, December 2009, <http://www.commonwealthfund.org/Publications/In-the-Literature/2009/Dec/Quality-Based-Payment-for-Medical-Groups-and-Individual-Physicians.aspx>.

Carriers reported on the types of metrics they use: quality, cost/utilization, or other metrics. Metric types were categorized based on the National Quality Measures Clearinghouse domains. Quality metrics include clinical quality measures, including process, access, outcome, structure, and patient experience measures. Cost/utilization metrics include the use of service, cost, and clinical efficiency. Finally, other metrics include domains such as user-enrollee health state and management.

Two of the three carriers make pay-for-performance payments to ACOs, hospitals and physicians based on quality of care metrics, while two also make payments to ACOs based on cost and utilization metrics, one makes payments to physicians based on cost and utilization metrics. See **Figure 3.21**.

Figure 3.21: Types of Metrics Used by 3 Large Carriers to Award Pay-for-Performance Payments

Provider type	# of Carriers Using Quality Metrics	# of Carriers Using Cost/Utilization Metrics
ACOs/PHOs	2	2
Hospitals	2	0
Physicians	2	1

Source: Authors' survey of 3 large carriers' 2011 data

Global and Bundled Payments and Risk Sharing

Carriers reported only two contracts in 2011 in response to the UMMS survey that relied on global payments. However, an earlier NHID report found that carriers paid for care using risk sharing contracts for 5% of fully insured members in 2009, increasing to 11% in 2011.⁷⁹ Similarly, the carriers who responded to the survey do not use bundled payments for chronic conditions such as asthma or diabetes, nor for acute orthopedic or obstetric care; only 0.1% of all payments were identified as bundled, used for other acute conditions.

⁷⁹ Bela Gorman et al., Gorman Actuarial, *New Hampshire Insurance Department 2011 Medical Cost Drivers*, December 2012.

4. Stakeholder Recommendations

Figure 4.1: Summary of Stakeholder Opinions

Market Dynamic	Payers	Providers	Purchasers
Can the state rely on Competition to contain costs?	<ul style="list-style-type: none"> Competitive insurance market Little provider competition 	<ul style="list-style-type: none"> No insurance competition 	<ul style="list-style-type: none"> No insurance competition
Best strategy to contain health care costs?	<ul style="list-style-type: none"> New payment models New contracting options 	<ul style="list-style-type: none"> More funding for Medicaid (reduce the need for cost-shifting) 	<ul style="list-style-type: none"> Healthy populations
State role?	<ul style="list-style-type: none"> Transparency Enable/encourage more competition for providers Look at provider efficiency and billing practices 	<ul style="list-style-type: none"> Transparency Support development of infrastructure for provider systems to manage patient populations 	<ul style="list-style-type: none"> Transparency

Source: Authors' 2013 stakeholder interviews

Below are seven major recommendations made by one or more of the interviewed stakeholders.

Stakeholder Recommendation #1: Develop a shared long term vision on promoting the health of the New Hampshire population, improving quality of care, and containing health care costs. Align policies and regulations to support the vision, for example, to guide decisions regarding investing in payers' and providers' infrastructure.

The NHID could convene other state agencies and key stakeholders to create a long term vision and health care agenda in New Hampshire.

In addition, the legislature could adopt legislation that creates a long term vision and agenda for the state, setting out a broad vision for health care in the state and creating specific mechanisms to enable the state to better assess health care costs with the intention of containing such costs in the future. Through legislation, New Hampshire could introduce cost growth targets for payers and providers across the state. The state could encourage the creation of patient-centered medical homes and accountable care organizations by creating a certification process for such entities. To promote the adoption of payment methods other than fee-for-service, the state could require private and public payers to develop and implement alternative payment methods. The law could also authorize task forces or commissions to examine and report on health care payment rates and payment systems, price variation among providers, and other cost-related issues.

Stakeholder Recommendation #2: Continue to support transparency and the development of tools that make information, utilization and cost data more accessible to providers, payers and consumers.

The NHID has made significant efforts to promote and facilitate information transparency in the state. The legislature could further enhance the disclosure of pricing information and patient data for transparency purposes. For example, the state could require carriers to disclose patient-level data to providers for treatment and care coordination and management and require NHID to develop procedures for such disclosures. The state could also prohibit contracts between carriers and health care providers from containing provisions that limit the ability of the carrier or health care provider to disclose the allowed amount or fee of services to the insured or the insured's treating provider, or to disclose out-of-pocket costs to the insured. One interviewee suggested that NHID "educate others to the missed opportunity of not sharing claims data with carriers."

Stakeholder Recommendation #3: The NHID should play a convening role in the development of new payment models, developing guidelines for new models, and supporting developmental pilots.

Stakeholders encouraged the state to promote accountability and innovations in pricing models, including expanded capitation arrangements, pay-for-performance and quality metrics and payments. To address this recommendation, New Hampshire could consider enacting legislation to encourage or require the development and adoption of alternative payment methods by payers. The NHID could work with other state agencies, carriers and providers, in accordance with all applicable antitrust laws and regulations, to develop "best practices" for payment models and related guidelines.

In addition, the legislature could grant the NHID specific authority to formally "certify" individual providers or provider organizations as able to take on the downside risk required by some new payment models. For example, under Massachusetts' Chapter 224, the Division of Insurance is required to examine risk-bearing provider organizations and issue risk certificates to those that meet certain standards of solvency. The Massachusetts law requires such certification, or a DOI-approved waiver, for providers that bear downside risk under an alternative payment contract.⁸⁰

Stakeholder Recommendation #4: The NHID and other state agencies should review and evaluate stakeholder payment issues to determine whether to intervene in the market.

Several stakeholder recommendations related to the business practices of providers and payers and suggest further analysis to clarify the scope of the issues and potential solutions. One area of concern among carriers was the billing of "hospital-based" services by providers for off-campus urgent care center services. Stakeholders also requested a mechanism that specifically allows carriers to selectively contract with individual entities or departments within larger provider systems rather than having to contract with the entire system or not at all. Another stakeholder suggestion was to require a standardized payment method among commercial payers. This stakeholder felt, for example, that if the all carriers used per diems to pay for inpatient care and used consistent definitions for services, that this would reduce administrative overhead for carriers and providers alike. One carrier said that providers want the same price from all carriers so they do not suffer if the carrier loses their account. A stakeholder said the "state should have minimum standards and feed into the rate-setting process, but not eliminate opportunities for innovation."

Finally, stakeholders voiced the need to address Medicaid payments, a complex issue involving legislative action and the involvement of New Hampshire's Department of Health and Human Services and the Centers for Medicare and Medicaid Services. A provider proposed other changes to the Medicaid

⁸⁰ Chapter 224 of the Acts of 2012 § 216; codified at M.G.L. c. 176T.

program: Currently under federal law, most immigrants who are not refugees or asylees are not eligible for federal benefits such as Medicaid until five years after they arrive in this country; the provider interviewed suggested reducing this wait time—note that states have the option of providing Medicaid coverage to children and pregnant immigrants lawfully residing in the United States, during that five year period, and coverage for emergency services for others. The provider would also like Medicaid to re-visit billable provider types, explaining that previously providers could bill for substance abuse services and a case management fee for pre-natal care to cover nutritional counseling or visits with a social worker; but now providers cannot bill for these wrap-around services.

Stakeholder Recommendation #5: Increase investment in primary care.

Stakeholders suggested three ways that New Hampshire could increase investment in primary care. The state could provide temporary funding to support ACO development for self-funded plans. The New Hampshire Citizen's Health Initiative is facilitating an ACO with several providers and carriers. For members enrolled in fully-insured products, carriers pay primary care providers a supplemental fee to cover the extra services required to manage members care effectively. One stakeholder proposed using revenue from taxes on tobacco and alcohol for smoking cessation and prevention.

Stakeholders also suggested that increased Medicaid payments could focus on primary care services, which, as indicated above, is a complex issue for the state to address. The ACA provides federal funding for two years to increase Medicaid payment rates for primary care to Medicare levels; this interim funding may alleviate cost pressures for primary care providers temporarily.

Some stakeholders recommended reinstating primary care contracts in the Office of Primary Care that were cut for key areas such as substance abuse, prenatal care and other needed critical services. One provider said all provider contracts were cut, including substance abuse for pregnant women and a 43% cut in primary care.

Stakeholder Recommendation #6. Reform the Certificate of Need process.

Every stakeholder group mentioned the Certificate of Need process, which falls within the authority of New Hampshire's Department of Health and Human Services, as an area to explore. Stakeholders recommended developing a Certificate of Need program objective and related rule sets to ensure new programs, equipment and facilities introduced into the market are consistent with the long-term vision for the state and allow access to the most affordable, highest quality services. NHID could work with DHHS and stakeholders to build a set of consensus recommendations for reforming the Certificate of Need process.

Additional Considerations

Stakeholders made many recommendations relating to areas that state agencies other than the NHID oversee. For example, the stakeholder recommendations regarding the Certificate of Need process and Medicaid rates are most relevant to New Hampshire's Department of Health and Human Services (DHHS). For that reason, the NHID may wish to consider distributing this report to those agencies and convening further discussions with such agencies on these topics.

Other recommendations may require new legislation. The New Hampshire legislature may wish to consider enacting a broad mandate by which state and private actors in the health care industry share in the responsibility to contain health care costs in the state; Massachusetts recently enacted such

legislation.⁸¹ In July 2012, Massachusetts adopted legislation (“Chapter 224”), to reduce the growth in health care costs in Massachusetts and improve health care quality and patient care, largely through (i) enforcement of cost growth benchmarks; (ii) promotion and regulation of alternative payment methods, patient-centered medical homes, and accountable care organizations; and (iii) collection and analysis of data from payers and providers. See **Appendix F** for an annual timeline of hearings, reports, and other activities mandated under Chapter 224.

Finally, as of early June 2013, it is unclear whether the legislature will enact specific legislation to align the market rules for New Hampshire’s individual and small group health insurance markets with ACA requirements that will take effect in 2014. Originally written as HB 668, and subsequently added as an amendment to SB 148, the current legislative proposal would, among other things, change the rating parameters in individual and small group markets to the four rating factors established by the ACA (tier/family v. self-only coverage, geographic rating area, age and tobacco use).

⁸¹ Certain provisions of Massachusetts’ new cost containment law, Chapter 224, relate to new authorities granted to Massachusetts’ Division of Insurance (MA DOI) or new requirements imposed on payers or providers. Although these statutory provisions are relatively new and MA DOI has yet fully tested them, the NHID and the other New Hampshire agencies may wish to consider certain of these provisions, at least in concept, as part of New Hampshire’s overall health care cost strategy moving forward. It is in that context that we point to select provisions of Chapter 224 in our discussion of several of the stakeholder recommendations in this section.

5. Conclusion

New Hampshire's health care premiums and deductibles are among the highest in the country. Cost is thus a concern for all stakeholders: consumers, carriers, providers, and employers.

The interviewed stakeholders often attributed the high cost of health care to a variety of factors, including:

- A lack of provider and carrier competition in rural areas;
- A lack of competition due to carrier dominance;
- A trend toward consolidation as hospitals buy up physician practices;
- An increase in the use of higher-cost sharing products; and
- A lack of transparent data regarding health care quality and cost.

The health care industry is beginning to utilize a holistic approach to reduce health care costs while simultaneously improving the quality of care and value achieved. Although competition may never be an effective force in cost reduction in New Hampshire, carriers have found success in plan design changes such as increased cost sharing and site of service plans. However, some providers and consumers are concerned that these products negatively affect patient care. To the extent that carriers increase their use of quality metrics, better data would become available to ensure that cost reduction is not the sole consideration to plan design changes.

Providers and carriers have also begun the process of reforming care delivery and the provider payment system, to use outcome performance as the lever to reduce unnecessary utilization of medical services and thus lower costs. Accountable care organizations (ACOs) are found throughout the state, and many use performance-based contracts. Again, as data becomes available, providers and carriers will be able to identify successful approaches to adopt.

The stakeholder interviews identified common reform themes from industry experts. Stakeholders repeatedly mentioned a need for state leadership in developing a long-term health care vision for New Hampshire, which would then inform other programs, such as the Certificate of Need process and level of primary care investment. During interviews, stakeholders also requested state assistance in identifying and sharing best practices in the industry. There was also a call for state involvement with the development of new payment models and oversight of the payment industry. Stakeholders also stated a desire for better access to cost and utilization data, as well as training and infrastructure to use data to improve health outcomes.

NHID and other government sectors will need to determine which stakeholder recommendations they feel are the most appropriate to enact, but New Hampshire has a clear opportunity to improve both how care is delivered to patients and how costs affect the health care industry and insurance system.

6. Appendices

Appendix A: Glossary

Cost Sharing Terms:⁸²

Co-insurance	<p>A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.</p> <ul style="list-style-type: none">• Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurer determines to be “usual, customary and reasonable”.• Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list.• In addition to overall coinsurance rates, rates may also differ for different types of services.
Co-payment	<p>A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement.</p> <ul style="list-style-type: none">• There may be separate copayments for different services.• Some plans require that a deductible first be met for some specific services before a copayment applies.
Deductible	<p>A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles.</p> <ul style="list-style-type: none">• Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission.• Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.
Premium	<p>Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor. For self-insured plans, a premium equivalent is calculated based on the cost per covered employee, or the amount the firm would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.</p>

Types of Products:⁸³

EPO (Exclusive Provider Organization)	<p>A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.</p>
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⁸² Bureau of Labor Statistics, *Definitions Of Health Insurance Terms* <http://www.bls.gov/ncs/ebs/sp/healthterms.pdf> (June 2013).

⁸³ Bureau of Labor Statistics, *Definitions Of Health Insurance Terms* <http://www.bls.gov/ncs/ebs/sp/healthterms.pdf> (June 2013).

HMO (Health Maintenance Organization)	A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.
Indemnity	A type of medical plan that reimburses the patient and/or provider as expenses are incurred. A “conventional indemnity plan” allows the participant the choice of any provider without effect on reimbursement.
PHO (Physician-hospital organization)	Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.
POS (Point of Service)	A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).
PPO (Preferred Provider Organization)	An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or nondiscounted charges from the providers.

Employer Funding Decision:⁸⁴

Fully insured plan	A plan where the employer contracts with another organization to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs.
Self-insured plan	A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.

Group Size:⁸⁵

Large Group	Group coverage for an employer that employed on average at least 51 persons, on business days, during the previous calendar year.
Non-group	Also called individual coverage, this is health coverage issued by a health carrier directly to an individual and not on a group

⁸⁴ Bureau of Labor Statistics, *Definitions Of Health Insurance Terms* <http://www.bls.gov/ncs/ebs/sp/healthterms.pdf> (June 2013).

⁸⁵ Based on definitions in the New Hampshire Revised Statutes Annotated (RSA) Index, <http://nhrsa.org/law/420-g-2-definitions/>

Small Group Group coverage for a business or organization which employed on average, one and up to 50 employees, including owners and self-employed persons, on business days during the previous calendar year.

Payment Terms from Carrier Survey

Charge-based payment: Includes contracts in which payments are based on the provider's billed charge, such as a percent of the provider's billed charge, 100% of billed charge, or arrangements in which the carrier limits the billed charge to some maximum (e.g. regional maximum).

- *With Pay-for-Performance:* Includes contracts that are based on a fee schedule, and in which the carrier makes additional payments or imposes payment penalties based on the provider's performance on specific quality, cost, or utilization goals.
- *No Pay-for-Performance:* Includes contracts that are based on a fee schedule, without additional payment or penalty based on performance goals.

Fee Schedule, with pay-for-performance: Include contracts in which payments are based on a standard fee schedule adopted by the carrier. Includes payments based on diagnostic related groups (DRGs), the Ambulatory Patient Classification (APC) model, or other grouping models.

- *With Pay-for-Performance:* Includes contracts that are based on a fee schedule, and in which the carrier makes additional payments or imposes payment penalties based on the provider's performance on specific quality, cost, or utilization goals.
- *No Pay-for-Performance:* Includes contracts that are based on a fee schedule, without additional payment or penalty is made based on performance goals.

Global payment: Include contracts that pay a provider for the total cost of care provided to a specific patient population that has been attributed to that provider. Global payments usually use a per member per month (PMPM) payment. Contracts which use fee-for-service but reconcile to a PMPM amount are also to be included as global payments.

- *No downside risk:* Includes contracts that use a global payment method, but do not place the provider at financial risk. Typically in these cases, the contract will include a hold-harmless provision to ensure that the provider receives the same payment under the global payment method as it would have received using a fee-for-service method. This includes contracts that have shared savings provisions with the provider, without shared loss provisions.
- *With downside risk:* Includes contracts that use a global payment method, but do place the provider at some level of financial risk.

Other: Contracts that use other payment methods that do not meet the categories outlined above.

Bundled payment: Defined as "a single payment is made for an episode of care—a defined set of services delivered by designated providers in specified health care settings, usually delivered within a certain period of time, related to treating a patient's medical condition or performing a major surgical procedure." ⁸⁶ It does not include payments based solely on DRG, APC, or Ambulatory Patient Groups (APGs) as bundled payment.

⁸⁶ [Mark Zezza, et al., *The Commonwealth Fund, The Bundled Payment for Care Improvement Initiative: Achieving High-Value Care with a Single Payment, January 2012.*](http://www.commonwealthfund.org/Blog/2012/Jan/Bundled-Payment-for-Care-Improvement.aspx)

Appendix B: Stakeholder Interviews

Methodology

FHC conducted the stakeholder interviews and subsequent summary findings. The goal of the interviews was to understand the drivers of health insurance premium rates and health care costs in general, and identify opportunities for state action that would contain or reduce the rate of increase.

Stakeholder Selection

The cost of health care coverage and health care services can influence a variety of stakeholders. The interview team therefore identified a comprehensive and inclusive list of potential interviewees. Three major categories of stakeholders were initially identified – purchasers, payers, and providers. To broaden the perspective, the project team added representatives of professional associations and regulators to the stakeholder roster.

The project team identified 35 organizations across all stakeholder groups with a goal of completing 25 interviews. The project team used the following criteria to select individuals and organizations:

- size and influence in the NH health care delivery or payment systems
- knowledge and experience with issues related to the drivers of health care costs
- past involvement in initiatives undertaken to address/improve health care costs
- willingness to engage with the state and other organizations in problem-solving on this topic
- Interviewee availability within project time frame

The following table shows the result of the prioritization.

Stakeholder Group	Total # Identified	High/Medium Priority	# Interviewed
Payer	9	8	8
Provider	19	16	13
Purchaser	5	5	4 (1 declined)
Regulator	2	1	1
Total	34	30	26

Of note, one stakeholder declined to participate in the process. To protect the confidentiality of the regulatory agency representative, this response is included in the provider section.

Questions and briefing paper

The project team developed interview questions for each stakeholder group to guide the conversation. Questions focused on the contracting environment, delivery system re-design, and new payment models that are most likely to have an influence on the costs of health care coverage and health care costs in general. Interviewees had an opportunity to share solutions to rate increase challenges. A full list of questions is included as Appendix 1.

Interview questions, which were tailored slightly for each stakeholder group, were sent in advance along with a briefing paper that summarized the purpose of the study, why an interview was being requested, and a summary of the key issues and concerns regarding health care costs in New Hampshire. The briefing paper is included as Appendix 2.

Interview process

The majority of interviews were conducted in person by one or two FHC representatives during April and May 2013. Conversations were guided by the interview questions previously distributed to the participants. In addition, interviewees had an opportunity to share background information that would provide context to their comments and result in a more meaningful discussion. Conversations were not limited to the question set. When an additional issue or concern that was raised by the interviewee, the interviewers captures this information.

Interviewees were assured that all responses would be kept confidential, and that no comment would be attributed to a single individual. The project team aggregated all findings by stakeholder group.

The following is the list of organizations that participated in the interview process.

Stakeholder Group	Organization
Payer	Aetna Anthem Centene Cigna Harvard Pilgrim Health Care Meridian MVP United HealthCare
Provider	Bedford Ambulatory Surgical Center Bi-State Primary Care Association Coos County Family Health Services Dartmouth Hitchcock Medical Center Lakes Region Hospital Lamprey Health Care Mid-State Health Center New London Hospital NH Hospital Association NH Medical Society Plymouth Regional Hospital Southern New Hampshire Medical Center Speare Memorial Hospital
Purchaser	NH Purchasers Group on Health Business and Industry Association of NH Hypertherm Hitchiner Manufacturing
Regulator	NH DHHS (<i>responses included in Provider section to protect confidentiality</i>)

**Background Paper and Interview Guide
New Hampshire Insurance Department – Key Stakeholder Interviews**

Introduction:

Health care in the US has been under public scrutiny for gaps in quality, challenges in access to care, and escalating costs that have made health insurance unaffordable to many Americans. NH faces these same challenges, perhaps with some differences due to the demographics, culture, economy, and geography of the Granite State.

The NH Insurance Department has engaged Freedman Healthcare and the University of Massachusetts to better understand the current health service contracting environment and provider payment system in New Hampshire and the impacts of that system on health insurance premium rates and health care costs generally. A critical component to this study will include structured interviews with over twenty key market stakeholders to gather detailed information on several aspects of the current NH health care and health insurance markets. The purpose of these interviews is to hear your perspective on recent market developments in New Hampshire, including but not limited to efforts to develop accountable care organizations (ACOs), incentive systems for using low-cost providers for certain services, network disruptions caused by the termination of large provider contracts, and, more generally, the effect that the necessity of acquiring a provider network has on carriers' decisions about market participation.

As an important stakeholder, your perspective, concerns, and suggestions regarding the health care contracting environment in NH will be an important addition to our study. To facilitate our upcoming conversation, we have summarized several important trends in health care markets and health care reform that are, in many cases, drivers of carrier and provider contracting strategies and may help set the context for our conversation.

Topics for Discussion:

Contracting Environment. New Hampshire's commercial market covers nearly 640,000 members, with three carriers covering 89% of the market.⁸⁷ Most of the self-funded employers have contracts with these same major carriers to administer their health care benefits. On the delivery system side, over the past year at least seven of NH hospitals have sought mergers or affiliations, according to press reports.

NH's 11% uninsured are fewer than the national rate (16%) but higher than neighboring ME (10%), VT (9%) and MA (4%)⁸⁸. Under the federal [Affordable Care Act](#), (ACA or Obamacare), NH has the option to expand Medicaid coverage to residents with income up to 138% of the federal poverty level (FPL). Gov. Hassan has announced her support for this expansion, which could cover about 50,000 residents. About 100,000 more residents (up to 400% of FPL) will become eligible for subsidized coverage through the health insurance Exchange beginning January 2014.

With expanded health insurance, increased demand for health care services will follow. Primary care shortages may appear or become more acute, particularly in currently underserved areas and areas that will have many newly-insured residents.

⁸⁷ New Hampshire Insurance Department. *Supplemental Report of the 2010 Health Insurance Market in New Hampshire*. April 2012. http://www.nh.gov/insurance/lah/documents/sup-rep_10.pdf.

⁸⁸ Kaiser Family Foundation <http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rqn=31>
Accessed 2/21/2013

Delivery System Redesign. Experiments in reorganizing providers to emphasize coordinated care, care teams and patient-centered care are underway across the country, and the Dartmouth Institute is recognized as a thought leader in the area of Accountable Care Organizations (ACOs). The goal of these efforts is to achieve better outcomes at lower costs, often referred to as “high value health care.” [ACOs](#) are networks of physicians, hospitals, and other providers that will bear financial risk for the quality and the cost of care for their patients. NH currently has four ACOs participating in Medicare demonstrations. [Patient-centered medical homes](#) are models of providing comprehensive primary care. Experts at the Dartmouth Institute assert that providing coordinated care through entities like ACOs and patient-centered medical homes is a promising approach to promoting high value health care⁸⁹.

Plan designs with increased cost sharing by members attempt to encourage patients to be cost-conscious when seeking medical care. In order to do so, consumers need timely and understandable information to make wise choices. Even under the ACA, evidence suggests that high cost sharing plans will continue to increase membership.

Payment Models. Medicare’s ACO and commercial global payment models may align payment incentives with delivery system redesign. These models pay providers a fixed-dollar amount for all the care provided to a patient over a period of time, e.g., one year. By “paying for outcomes” rather than paying for discrete services, attention to quality, coordination and cost-effectiveness are expected to follow. Payment reform represents both risk and opportunity for payers and providers alike. For example, provider organizations forming ACOs are subject to federal anti-trust laws.

Short of global payments, intermediate forms of payment reform are more widespread. [Pay-for-performance](#) contracts include bonus or penalty provisions based on the quality and cost of care. [Bundled payments](#) are a single sum paid by the insurer to the facility and physicians who care for a patient, and are most commonly used in obstetrics and elective major surgery (e.g., knee replacements).

Network Development & Market Factors. Many markets in the US have struggled with the tradeoffs presented by provider consolidation. Provider leverage may be due to size or geography (e.g., a solitary hospital serving a portion of the state). NH’s geography results in a number of locally dominant providers. Larger providers may also have greater contracting leverage and may have greater capacity to coordinate care, use economies of scale, and safely bear financial risk.

Potential Solutions. We would like to hear your thoughts on how the NH health care market and contracting practices affect you and these issues, and to learn your ideas for moving New Hampshire toward higher quality and more cost-effective care for the benefit of NH residents and businesses.

⁸⁹ The Dartmouth Institute, Accountable Care Organizations, <http://tdi.dartmouth.edu/initiatives/accountable-care-organizations> Accessed 2/25/2013.

Interview Questions for Each Stakeholder Group

Interview Questions for Carriers

1. Contracting environment

- a. What is your impression of the competitiveness of the health insurance market in New Hampshire? The provider market?
- b. What is your overall impression of the health care provider contracting environment in NH?
- c. Which aspects of the current contracting environment appear to be functioning well for the state of NH and its residents? Which are functioning poorly?
- d. What impact has this environment had on health care costs? Explain.
- e. More specifically, what impact has this environment had on health insurance premium rates?
- f. Does the current contracting environment promote high value for consumers?
- g. Do you see the contracting process as an opportunity to engage in a dialogue regarding strategies and goals related to high quality, low cost care? Could you envision it playing that role? What needs to change to get there? What are impediments to that?
- h. In what ways is your organization advantaged/disadvantaged relative to your competitors?
- i. Has the trend toward increased patient cost sharing been a factor in your negotiations? In what way?
- j. How does the contracting environment in NH compare to other states?
- k. Is the number or intensity of contract disputes increasing or decreasing?
- l. What could the state do to improve the contracting environment in NH?
- m. Are there changes the legislature could make to state law to improve the contracting environment? If so, what are they? Please be specific.

2. Delivery system re-design

- a. To what extent have providers in your network formed accountable care organizations (ACOs)? How have ACOs affected or will they affect high value health care, positively or negatively?
- b. Is there too little, enough, or too much emphasis on ACOs and their potential to contain costs and improve quality?
- c. What role should the state play in monitoring (or regulating) ACOs, e.g. setting minimum standards? What about the federal government or specifically CMS?
- d. To what extent have providers in your network created Patient Centered Medical Homes? How have Patient Centered Medical Homes affected or will they affect high value health care, positively or negatively?
- e. Is there too little, enough, or too much emphasis on Patient Centered Medical Homes and their potential to contain costs and improve quality?
- f. To what extent have providers in your network engaged in other initiatives to contain costs and improve quality?
- g. What incentives have you implemented to encourage members to use low cost providers for certain services (such as site of service or tiered networks)? Does your organization have data documenting that these incentives have successfully lowered costs? Can you share this data with us?
- h. What has been your organization's experience with high member cost (high deductible or high co-pay) products? What effect do these products have on cost and quality of health care?

3. Payment Models

- a. To what extent has your organization begun to pay providers using alternative payment arrangements (e.g., P4P, bundled payments, global payments, etc.)?
- b. Do you think payment/contracting arrangements can affect quality of care? If so, which arrangements and in what way?
- c. Which payment/contracting arrangements are most likely to contain costs?
- d. Have you seen data from your own organization that suggests that alternative payment models are affecting costs or quality? Can you share that data with us?
- e. Which payment/contracting arrangements are most embraced or resisted by your organization? By other stakeholders?
- f. Have providers expressed interest in or resistance to accepting more risk? What are the barriers to providers' ability to bear risk?
- g. What role should the state play in monitoring risk-bearing arrangements?

4. Network development & market factors

- a. Describe your organization's experience in developing a provider network.
- b. How difficult is it to develop a provider network with competitive rates in NH, as compared to other markets? Is this a barrier to new insurer entrants to the NH market?
- c. How do you feel the threat of network disruptions (e.g., the termination of large provider contracts) affects the decisions of carriers to participate in the NH market?
- d. Are there barriers to carriers entering NH? How could these barriers be addressed?

5. Potential solutions

- a. What efforts do you know of in NH or elsewhere in the country that offer promise of cost control if implemented in NH statewide?
- b. How do you see the role of insurance carriers changing?
- c. What could the state of NH, or specifically the Insurance Department do to support providers and payers moving towards high value health care?
- d. What information would you like to see available in the public domain?

Interview Questions for Providers

1. Contracting environment

- a. What is your impression of the competitiveness of the health care provider market in New Hampshire? The insurance market?
- b. What is your overall impression of the health care provider contracting environment in NH?
- c. Which aspects of the current contracting environment appear to be functioning well for the state of NH and its residents? Which are functioning poorly?
- d. What impact has this environment had on health care costs? Explain.
- e. More specifically, what impact has this environment had on health insurance premium rates?
- f. Does the current contracting environment promote high value for consumers?
- g. Do you see the contracting process as an opportunity to engage in a dialogue regarding strategies and goals related to high quality, low cost care? Could you envision it playing that role? What needs to change to get there? What are impediments to that?
- h. How do your contracts differ from insurer to insurer? What works well? What needs to change?
- i. Are Medicare and Medicaid rates a factor in negotiations with commercial carriers? If so, how?
- j. What factors have had the largest effect on your ability to negotiate with insurance companies?
- k. In what ways is your organization advantaged/disadvantaged relative to your competitors?
- l. What could the state do to improve the contracting environment in NH?
- m. Are there changes the legislature could make to state law to improve the contracting environment? If so, what are they? Please be specific.

2. Delivery system re-design

- a. Would you consider your organization to be an ACO? Are there providers (e.g. physicians, affiliates) participating in other ACOs? If so, describe. If not, what efforts are you making, if any, to transform the way you deliver care?
- b. How have ACOs affected or will they affect high value health care, positively or negatively? Is there too little, enough, or too much emphasis on ACOs and their potential to contain costs and improve quality?
- c. What role should the state play in monitoring (or regulating) ACOs, e.g. setting minimum standards? What about the federal government or specifically CMS?
- d. Has your organization implemented a Patient-Centered Medical Home model or other coordinated care models? How have Patient Centered Medical Homes affected or will they affect high value health care, positively or negatively?
- e. Is there too little, enough, or too much emphasis on Patient Centered Medical Homes and their potential to contain costs and improve quality?
- f. What incentives, if any, have you implemented to encourage your patients to seek services within your network? What has been the reaction from patients? What has been the reaction from carriers?
- g. In general and for your organization, is there an interest in or resistance to bearing risk? What barriers are there to your ability to bear risk?
- h. How do you see the role of insurance carriers changing?
- i. What has been your organization's experience with high member cost (high deductible or high co-pay) products? What effect do these products have on the cost or quality of health care?
- j. To what extent has your organization engaged in other initiatives to contain costs and improve quality?

3. Payment

- a. To what extent has your organization begun to accept alternative payment arrangements (e.g., P4P, bundled payments, global payments, etc.)?
- b. Are you participating in Medicare's alternative payment models (e.g. Shared Savings and Pioneer ACOs)? How do the incentives differ between these Medicare payment systems and your commercial contracts? How does that influence your organization?
- c. Do you think payment/contracting arrangements can affect quality of care? If so, which arrangements and in what way?
- d. Which payment/contracting arrangements are most likely to contain costs?
- e. Which payment/contracting arrangements are most embraced or resisted by your organization? By other stakeholders?

4. Potential solutions

- a. What efforts do you know of in NH or elsewhere in the country that offer promise of cost control if implemented in NH statewide?
- b. What could the state of NH, or specifically the Insurance Department do to support providers and payers moving towards high value health care?
- c. What information would you like to see available in the public domain?

Interview Questions for Purchasers and Consumer Associations

1. Contracting environment

- a. What is your impression of the competitiveness of the health insurance market in New Hampshire? The provider market?
- b. What is your overall impression of the health care provider contracting environment in NH?

- c. Which aspects of the current contracting environment appear to be functioning well for the state of NH and its residents? Which are functioning poorly?
- d. What impact has this environment had on health care costs? Explain.
- e. More specifically, what impact has this environment had on health insurance premium rates?
- f. Does the current contracting environment promote high value for consumers?
- g. Do you see the contracting process as an opportunity to engage in a dialogue regarding strategies and goals related to high quality, low cost care? Could you envision it playing that role? What needs to change to get there? What are impediments to that?
- h. What could the state do to improve the contracting environment in NH?
- i. Are there changes the legislature could make to state law to improve the contracting environment? If so, what are they? Please be specific.

2. Delivery system re-design

- a. To what extent have providers in your community formed accountable care organizations (ACOs)? How have ACOs affected or will they affect high value health care, positively or negatively?
- b. Is there too little, enough, or too much emphasis on ACOs and their potential to contain costs and improve quality?
- c. What role should the state play in monitoring (or regulating) ACOs, e.g. setting minimum standards? What about the federal government or specifically CMS?
- d. To what extent have providers in your community created Patient Centered Medical Homes? How have Patient Centered Medical Homes affected or will they affect high value health care, positively or negatively?
- e. Is there too little, enough, or too much emphasis on Patient Centered Medical Homes and their potential to contain costs and improve quality?
- f. To what extent have providers in your community engaged in other initiatives to contain costs and improve quality?

3. Purchaser experience

- a. What are employers'/consumers' concerns about emerging insurance products (e.g., tiered, limited network, high deductible, etc.)? What trends in insurance products are encouraging/discouraging to you?
- b. What has been your organization's experience with high deductible HSA or high co-pay products? What products do you offer? How many lives enrolled in these products?
- c. What are your employees'/members' feelings about limited networks that cost less but offer less choice of provider?
- d. Does your organization have an opportunity to drive care to high quality, low cost health care? How?
- e. Have you incorporated benefit design characteristics intended to influence use of health care?

4. Potential solutions

- a. What efforts do you know of in NH or elsewhere in the country that offer promise of cost control if implemented in NH statewide?
- b. What could the state of NH, or specifically the Insurance Department do to support providers and payers moving towards high value health care?
- c. How do you see the role of insurance carriers changing?
- d. What information would you like to see available in the public domain?

Interview Questions for Regulators

1. Contracting environment

- a. What is your impression of the competitiveness of the health care provider market in New Hampshire? The insurance market?
- b. What is your overall impression of the health care provider contracting environment in NH?
- c. Which aspects of the current contracting environment appear to be functioning well for the state of NH and its residents? Which are functioning poorly?
- d. What impact has this environment had on health care costs? Explain.
- e. More specifically, what impact has this environment had on health insurance premium rates?
- f. Does the current contracting environment promote high value for consumers?
- g. Do you see the contracting process as an opportunity to engage in a dialogue regarding strategies and goals related to high quality, low cost care? Could you envision it playing that role? What needs to change to get there? What are impediments to that?
- h. What could the state do to improve the contracting environment in NH?
- i. Are there changes the legislature could make to state law to improve the contracting environment? If so, what are they? Please be specific.

2. Delivery system re-design

- a. To what extent have providers in the state formed accountable care organizations (ACOs)? How have ACOs affected or will they affect high value health care, positively or negatively?
- b. Is there too little, enough, or too much emphasis on ACOs and their potential to contain costs and improve quality?
- c. What role should the state play in monitoring (or regulating) ACOs, e.g. setting minimum standards? What about the federal government or specifically CMS?
- d. To what extent have providers in the state created Patient Centered Medical Homes? How have Patient Centered Medical Homes affected or will they affect high value health care, positively or negatively?
- e. Is there too little, enough, or too much emphasis on Patient Centered Medical Homes and their potential to contain costs and improve quality?
- f. To what extent have providers in the state engaged in other initiatives to contain costs and improve quality?

3. Potential solutions

- a. What efforts do you know of in NH or elsewhere in the country that offer promise of cost control if implemented in NH statewide?
- b. What could the state of NH, or specifically the Insurance Department do to support providers and payers moving towards high value health care?
- c. How do you see the role of insurance carriers changing?
- d. What information would you like to see available in the public domain?

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Appendix C: Carrier Survey

Instructions for Carriers

The New Hampshire Insurance Department (Department) has recently engaged a team from the University of Massachusetts Medical School and Freedman HealthCare to assist the Department in better understanding the current health service provider payment system in New Hampshire and the impacts of that system on health insurance premium rates and health care costs generally. This initiative is funded by the U.S. Department of Health and Human Services as a Premium Rate Review grant.

This survey is intended to collect data from carriers regarding the use of various payment arrangements and insurance products. The data collected from the survey will be aggregated and included in the final report, expected to be released in June 2013. No carrier-specific data will be published in the report. The survey consists of an Excel spreadsheet with a cover page and three worksheets, each of which includes two tables as listed here:

Worksheet 1:	Payment Arrangements
Table 1-A:	Arrangements by Provider and Type
Table 1-B:	Pay-for-Performance Programs
Worksheet 2:	Bundled Payments
Table 2-A:	Acute Conditions
Table 2-B:	Chronic Conditions
Worksheet 3:	Tiered Networks
Table 3-A:	Product by Plan Type
Table 3-B:	Tiering Criteria

Please complete the entire survey, including the cover page and each of the three worksheets, according to the following instructions:

- The time period of data requested is from calendar year 2011.
- Report only data pertaining to providers located in New Hampshire.

We ask that you complete this survey by April 19, 2013. Please email the completed survey to Michael Grenier at michael.grenier@umassmed.edu. If you have questions regarding this survey, please contact Michael at (617) 886-8160 or at the email noted above.

The following pages provide specific instructions for each of the tables in the survey.

Table 1A: Arrangements by Provider and Type

The purpose of this table is to collect data pertaining to the types of payment arrangements currently in use by New Hampshire insurance carriers.

Provider types (columns):

Please report data based on the type of provider entity that has executed the contracts with the carrier. Provider types include the following:

- *Accountable Care Organization (ACO) or Physician Hospital Organization (PHO).* An ACO is an entity in which health care providers – typically primary care providers and optionally including a hospital or specialists – take joint responsibility for a defined patient population, coordinate their care across settings, and are held to benchmark levels of quality and cost. A PHO is a separate legal entity comprised of a hospital and its attending medical staff, typically for the purpose of managed care contracting; for purposes of this survey, please do not include as a PHO an organization that is licensed as a hospital that employs physicians or has subsidiaries of other provider types.
- *Hospital Inpatient and Outpatient.* Include contracts with any entity licensed by the State of New Hampshire as a hospital, including rehabilitation and psychiatric hospitals.
- *Physician Practices.* Include contracts with any physician or physician group, including multispecialty groups and hospital-owned physician groups.
- *Other providers.* Include contracts with other provider types not included in previous columns, including, but not limited to: community health centers, skilled nursing facilities, suppliers of medical equipment, pharmacies, home health agencies, laboratories, ambulatory surgery centers, and freestanding radiology centers.

Data fields (columns):

- *Number of provider contracts.* Report the total number of provider contracts. If the provider has multiple contracts due to renewals during the year, report once based on the most recent contract. If the carrier has a single contract with an entity that includes payments for each service type, please count each service type method as a separate contract (i.e. report 1 under inpatient, 1 under outpatient, etc.).
- *Total Payments.* Report the total payments made to the provider. For claims payments, report based on the allowed amount. Include pay-for-performance, global payment settlements, and other non-claims payments.
- *Total charges.* Report the total billed charges from the provider.

Payment Methods (rows):

- *Charge-based payment:* Include contracts in which payments are based on the provider's billed charge, such as a percent of the provider's billed charge, 100% of billed charge, or arrangements in which the carrier limits the billed charge to some maximum (e.g. regional maximum).
 - *With Pay-for-Performance.* Include contracts that are based on a fee schedule, and in which the carrier makes additional payments or imposes payment penalties based on the provider's performance on specific quality, cost, or utilization goals.

- *No Pay-for-Performance.* Include contracts that are based on a fee schedule, without additional payment or penalty based on performance goals.
- *Fee Schedule, with pay-for-performance.* Include contracts in which payments are based on a standard fee schedule adopted by the carrier. Includes payments based on diagnostic related groups (DRGs), the Ambulatory Patient Classification (APC) model, or other grouping models.
 - *With Pay-for-Performance.* Include contracts that are based on a fee schedule, and in which the carrier makes additional payments or imposes payment penalties based on the provider's performance on specific quality, cost, or utilization goals.
 - *No Pay-for-Performance.* Include contracts that are based on a fee schedule, without additional payment or penalty is made based on performance goals.
- *Global payment.* Include contracts that pay a provider for the total cost of care provided to a specific patient population that has been attributed to that provider. Global payments usually use a per member per month (PMPM) payment. Contracts which use fee-for-service but reconcile to a PMPM amount are also to be included as global payments.
 - *No downside risk.* Include contracts that use a global payment method, but do not place the provider at financial risk. Typically in these cases, the contract will include a hold-harmless provision to ensure that the provider receives the same payment under the global payment method as it would have received using a fee-for-service method. This includes contracts that have shared savings provisions with the provider, without shared loss provisions.
 - *With downside risk.* Include contracts that use a global payment method, but do place the provider at some level of financial risk.
- *Other.* Indicate contracts that use other payment methods that do not meet the categories outlined above. Describe in the box provided.

Table 1B: Pay-for-Performance programs

Report the total amount of pay-for-performance payments or penalties by provider type.

Metric types are categorized based on the National Quality Measures Clearinghouse domains. Please refer to the Clearinghouse website located at <http://www.qualitymeasures.ahrq.gov/index.aspx>. If the exact measure is not available in the Clearinghouse but a reasonably similar measure is, carriers should report based on the domain of the similar measure.

Quality Measures include metrics in the Clinical Quality Measure domain, including process, access, outcome, structure, and patient experience measures.

Cost/Utilization Measures include metrics in the Use of Service, Cost, and Clinical Efficiency domains.

Other Measures include measures in all other domains, such as User-Enrollee Health State, and Management. Also include any measure that that is not listed in the Clearinghouse.

Tables 2A & 2B: Bundled Payment programs

The purpose of these tables is to collect data on bundled payment arrangements.

Bundled payment is defined as “a single payment is made for an episode of care—a defined set of services delivered by designated providers in specified health care settings, usually delivered within a certain period of time, related to treating a patient’s medical condition or performing a major surgical procedure. “⁹⁰ Do not include payments based solely on DRG, APC, or Ambulatory Patient Groups (APGs) as bundled payment.

Data fields (columns):

- *Number of provider contracts.* Report the total number of provider contracts. If the provider has multiple contracts due to renewals during the year, report once based on the most recent contract.
- *Total Payments.* Report the total payments made to the provider. For claims payments, report based on the allowed amount. Include pay-for-performance, global payment settlements, and other non-claims payments.
- *Total charges.* Report the total billed charges from the provider.
- *Episodes.* Table 2A requires carriers to report the number of episodes, as defined by the carrier for the particular clinical condition.
- *Member months.* Table 2B, chronic conditions, requires carriers to report the number of member months for which the bundled payment arrangement was applied.

Report the bundled payment arrangement under the appropriate contracting entity, using definitions listed in Table 1A.

If the carrier has a bundled payment arrangement for a different clinical condition not indicated here, please describe it in the boxes provided.

Table 3A: Product by plan type

The purpose of these tables is to collect data regarding the use of limited and tiered networks, using the following definitions:

Limited network products: The member is covered for care received at participating network providers, but out-of-network non-emergency care is not covered.

Unlimited network products: The member is covered for care received at network and non-network providers. This includes products that require higher patient cost sharing for out-of-network care.

Tiered: The carrier assigns hospitals or physician practices to different tier levels based on a defined set of quality, cost, or utilization metrics. Patients incur varying levels of cost-sharing based on the tier of the provider from which they receive care. For the purposes of this survey, a product that tiers only prescription drugs should not be reported as a tiered product.

Not tiered: The carrier does not vary patient cost-sharing based on tiers of hospitals or physician practices. Report as *Not Tiered* any product that only varies cost-sharing based on tiers of prescription drugs.

Table 3B: Tiering Criteria

Report the types of metrics used to assign providers to tiers. See the definitions in Table 1B for the definitions of the types of metrics.

⁹⁰ <http://www.commonwealthfund.org/Blog/2012/Jan/Bundled-Payment-for-Care-Improvement.aspx>

Carrier Survey

Payment Arrangements

1A: Arrangement by Provider and Type

	Accountable Care Organizations or Physician Hospital Organizations			Hospital Inpatient			Hospital Outpatient			Physician Practices			Other Providers			TOTAL		
Payment Method	Number of Provider Contracts	Total Payments	Total Charges	Number of Provider Contracts	Total Payments	Total Charges	Number of Provider Contracts	Total Payments	Total Charges	Number of Provider Contracts	Total Payments	Total Charges	Number of Provider Contracts	Total Payments	Total Charges	Number of Provider Contracts	Total Payments	Total Charges
Charge-based payment, with pay-for-performance																0	\$0	\$0
Charge-based payment, without pay-for-performance																0	\$0	\$0
Fee Schedule, with pay-for-performance																0	\$0	\$0
Fee Schedule, without pay-for-performance																0	\$0	\$0
Global Payment (No downside risk)																0	\$0	\$0
Global Payment (w/downside risk)																0	\$0	\$0
Other (Specify*)																0	\$0	\$0
Total	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0	0	\$0	\$0

Specify Other *

1B: Pay-for-Performance programs

	Total amount of pay-for-performance payments or penalties	What type of metrics are included in your pay-for-performance models? Indicate by Yes/No.		
		Quality	Cost/ Utilization	Other
ACOs/PHOs		No	No	No
Hospitals		No	No	No
Physicians		No	No	No
Other Providers		No	No	No
Total	\$0			

Bundled Payments

**2A. Bundled Payments
by Condition**

	Accountable Care Organizations or Physician Hospital Organizations			Hospitals			Physician Practices			Other		
ACUTE CONDITIONS	Number of Provider Contracts	Total Payments	Episodes	Number of Provider Contracts	Total Payments	Episodes	Number of Provider Contracts	Total Payments	Episodes	Number of Provider Contracts	Total Payments	Episodes
Orthopedic procedures												
Obstetric Care												
Other acute*												
Total	0	\$0	0	0	\$0	0	0	\$0	0	0	\$0	0

* List conditions:

CHRONIC CONDITIONS	Accountable Care Organizations or Physician Hospital Organizations			Hospitals			Physician Practices			Other		
	Number of Provider Contracts	Total Payments	Member Months	Number of Provider Contracts	Total Payments	Member Months	Number of Provider Contracts	Total Payments	Member Months	Number of Provider Contracts	Total Payments	Member Months
Asthma												
Diabetes												
Congestive Heart Failure												
Other chronic*												
Total	0	\$0	0	0	\$0	0	0	\$0	0	0	\$0	0

* List conditions:

Tiered Networks

3A: Product by Plan Type

Plan Type	Limited Network Products				Unlimited Network Products				TOTAL	
	Tiered (Uses tiering for hospitals or physicians)		Not Tiered (Does NOT use tiering for hospitals or physicians)		Tiered (Uses tiering for hospitals or physicians)		Not Tiered (Does NOT use tiering for hospitals or physicians)			
	Member Months	Total Payments	Member Months	Total Payments	Member Months	Total Payments	Member Months	Total Payments	Member Months	Total Payments
HMO									0	\$0
POS									0	\$0
EPO									0	\$0
PPO									0	\$0
Indemnity									0	\$0
TOTAL	0	\$0	0	\$0	0	\$0	0	\$0	0	\$0

3B. Tiering Criteria

	Which provider types are assigned to tiers in your network? Indicate by Yes/No.	What type of metrics are used to tier providers? Indicate by Yes/No.		
		Quality	Cost/Utilization	Other
Acute Hospitals	Yes/No	Yes/No	Yes/No	Yes/No
Primary Care Physicians	Yes/No	Yes/No	Yes/No	Yes/No
Specialty Physicians	Yes/No	Yes/No	Yes/No	Yes/No
Drugs	Yes/No	Yes/No	Yes/No	Yes/No
Psychiatric Hospitals	Yes/No	Yes/No	Yes/No	Yes/No
Rehab Hospitals	Yes/No	Yes/No	Yes/No	Yes/No
Ambulatory Surgical Centers	Yes/No	Yes/No	Yes/No	Yes/No
Laboratories	Yes/No	Yes/No	Yes/No	Yes/No
Freestanding radiology	Yes/No	Yes/No	Yes/No	Yes/No
Other providers (indicate below)	Yes/No	Yes/No	Yes/No	Yes/No

Appendix D: Herfindahl-Hirschman Index (HHI) explanation and methodology

The Herfindahl-Hirschman Index (HHI) shows the level of competitiveness in a region and is calculated based on market share for each entity in a region.

Calculation method

The HHI score is calculated by squaring each entity's market share, then summing the squares to create the HHI score. The table below shows an example of how the HHI is calculated.

Carrier	Market Share (% of members)	Square of market share
A	20%	400
B	50%	2,500
C	30%	900
Total (HHI score)		3,800

Thus regions where most entities have similar market shares (such as 10 insurance carriers each with 5%-15% of the market) will have low HHI scores, while a region with a few strong entities (such as one carrier with a 50% market share and 9 carriers with approximately 5% each) will have a high HHI score.

For carriers, the market share in this study was defined as the percent of total members. For hospitals, the market share was defined as percent of total payments (allowed amount).

Interpretation of results

If the score is...

<1,500

1,500-2,500

>2,500

that indicates...

the market is not concentrated

the mark has moderate concentration

a highly concentrated market

The Department of Justice and the Federal Trade Commission use the HHI, among other analyses, to determine whether a merger or acquisition precipitates anti-trust concerns. More information is available at <http://www.justice.gov/atr/public/guidelines/hhi.html> and <http://www.justice.gov/atr/public/guidelines/hmg-2010.html#5c>.

Appendix E: Supplemental Figures and Data

Below are supplemental data tables and figures referenced in the report.

Figure 7.1: Self-insured vs. Fully Insured by Group Size and Plan Type

(Source: Authors' analysis of 2011 NHCHIS data)

Group size	Plan	Fully Insured	Fully Insured %	Self-Insured	Self-Insured %	Grand Total*
Large Group		129,976	100%	358,315	100%	488,567
	EPO	8,505	7%	14,121	4%	22,626
	HMO	72,881	56%	90,804	25%	163,685
	Indemnity	5,376	4%	18,300	5%	23,677
	POS	7,079	5%	83,811	23%	90,890
	PPO	36,135	28%	151,280	42%	187,690
Small Group		84,938	100%	5,542	100%	90,483
	EPO	10,727	13%		0%	10,727
	HMO	58,721	69%	433	8%	59,154
	Indemnity	31	0%	0	0%	31
	POS	1,454	2%	21	0%	1,475
	PPO	14,005	16%	5,088	92%	19,096
Non-Group		30,393	100%	No membership reported		34,293
	HMO	117	0%			117
	Indemnity	1,341	4%			2,895
	PPO	28,935	95%			31,281
Grand Total		266,254		371,279		641,712

**total of 641,712 members includes 28,369 in other group size plans and 4,179 members not in fully insured or self-insured plans*

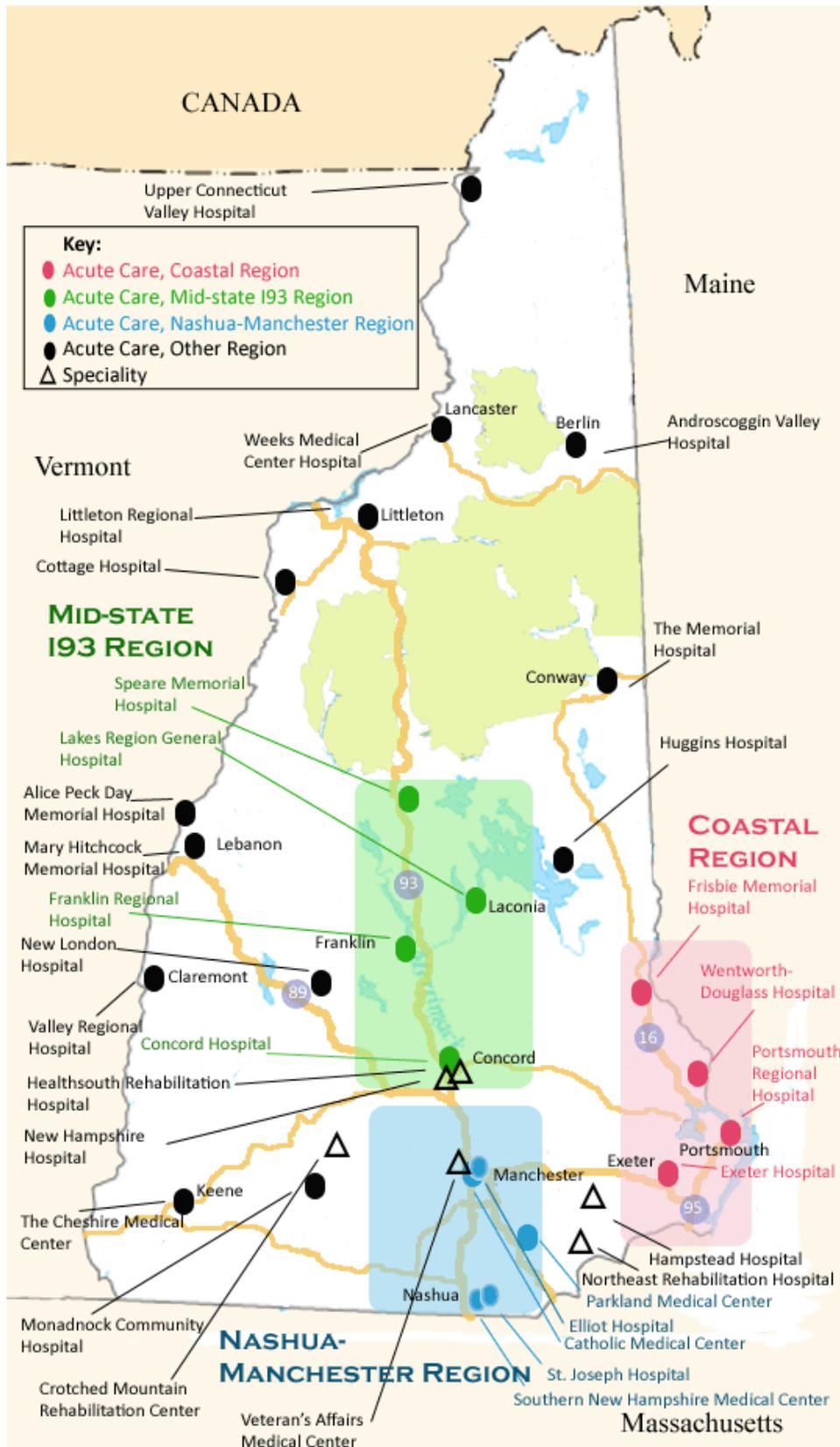
Figure 7.2: Types of providers and metrics used by three large carriers for their tiered networks

each check mark (✓) represents one of the three carriers.

Types of providers	In tiered network?	Quality metrics	Cost/Utilization metrics
Acute Hospitals	✓✓	✓	✓✓
Primary Care Physicians	✓✓	✓	✓✓
Specialty Physicians	✓✓	✓	✓✓
Drugs			
Psychiatric Hospitals			
Rehab Hospitals	✓		✓
Ambulatory Surgical Centers	✓✓✓		✓✓✓
Laboratories	✓✓✓		
Freestanding radiology	✓		

Source: Authors' 2013 survey of 3 large carriers

Figure 7.3: Map of NH Acute Care and Specialty Hospitals



Appendix F: Massachusetts Ch. 224 Implementation Timeline

The annual calendar below shows report deadlines, hearing dates, and other deadlines mandated by Massachusetts Ch. 224 of the Acts of 2012, “An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation.” Ch. 224 created the Health Policy Commission (HPC), an independent state agency charged with monitoring the health care delivery and payment system reform in Massachusetts and developing health policy in order to reduce cost growth while improving the quality of patient care. In addition, Ch. 224 created the Center for Health Information and Analysis (CHIA), which assumed functions previously sited under the former Division of Health Care Finance and Policy (DHCFP).

- **January 15 each year: Development of Growth Rate of Potential Gross State Product**
 - The Secretary of Administration and Finance, with the House and Senate Committees on Ways and Means, “shall jointly develop a growth rate of potential gross state product” (exception: if there is a new governor, the deadline gets extended to January 31). Ch. 224 §30; MGL c 29 §7H1/2
- **January 15-31 each year starting 2018: Request to Modify of Health Care Cost Benchmarks**
 - The HPC may submit notice of intent to modify health care cost benchmarks from their statutory parameters. If the legislature does not pass a bill preventing modification within 105 days of HPC’s submission, the benchmarks may be modified. Ch. 224 §15; MGL c 6D §9
- **April 15 each year: Establishment of Health Care Cost Benchmarks**
 - HPC shall establish health care cost growth benchmarks according to the potential gross state product and the formula dictated in statute (unless a modification occurred as detailed above). Ch. 224 §15; MGL c 6D §9
- **September 1 or earlier each year: CHIA Annual Report**
 - CHIA shall submit its annual report to HPC, based on information collected by CHIA and HPC. The report shall include a list of providers and provider organizations “that are paid more than 10 per cent above or more than 10 per cent below the average relative price and by identifying payers which have entered into alternative payment contracts that vary by more than 10 per cent.” (CHIA must submit report at least 30 days before HPC hearings, so if HPC decides to hold hearings earlier, CHIA must submit annual report earlier) Ch. 224 §19; MGL c 12C §16.
- **October 1 or earlier each year: HPC Annual Hearings**
 - HPC shall hold public hearings based on the CHIA annual report. Ch. 224 §15; MGL c 6D §8
- **December 31 each year: HPC Annual Report**
 - HPC shall release a report to the public, including legislative language necessary to implement recommendations.
- **Ongoing: CHIA communication with HPC**
 - CHIA shall identify and “confidentially provide” to HPC a list of “payers, providers and provider organizations” whose “increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark” such that HPC may pursue further action. Ch. 224 §19; MGL c 12C §18
- **Starting in 2015: Performance Improvement Plans**

- HPC **may**, for any health care entity⁹¹ identified by the CHIA annual report as exceeding the benchmark, require those entities to file and implement a performance improvement plan (or request waiver). Ch. 224 §15; MGL c 6D §10
- **Civil Penalties**
 - HPC **may** levy civil penalties up to \$500,000 for health care entities who do not cooperate. Ch. 224 §15; MGL c 6D §10(q)
- **CHIA Data Collection**
 - CHIA assumes responsibility for promulgating regulations and collecting data from payers (previously under Division of Health Care Finance and Policy). CHIA collects **new** information and engages **new** providers and payers, listed in part below. Ch. 224 s 19; MGL c 12C ss 3, 8-12
 - Prices of health care services;
 - Data from parent organizations and any other affiliated entities of institutional providers;
 - Data from provider organizations;
 - Total payroll as percent of operating expenses and salary and benefits of the top 10 highest compensated employees for acute hospitals;
 - Agreements between providers regarding remuneration in exchange for provision of health care services;
 - Data from third party administrators;
 - Changes in the type of payment methods implemented by payers and number of members covered;
 - Information about behavioral health carve outs; and
 - The annual rate of growth of private and public payers
 - **CHIA website**
 - CHIA assumes responsibility for DHCFFP’s duty to report on total medical expenses on its website. CHIA is additionally required to include “a breakdown of health status adjusted total medical expenses by major service category and by payment methodology.” Ch. 224 §19; MGL c 12C §8(d)

Acknowledgements

The University of Massachusetts’ Center for Health Law and Economics and Freedman Healthcare, LLC wish to thank all of the stakeholders who generously gave their time for interviews. The interviewees’ depth of knowledge about New Hampshire’s health insurance market and insights into current strengths, weaknesses, and potential areas for reform greatly aided the production of this report. We would also like to thank the carriers who provided information for the carrier survey, since it contributed to our understanding of the extent of market reforms in New Hampshire.

⁹¹ Health care entities are specifically defined in MGL c 6D §10(a) to exclude entities below a certain threshold of patients or annual net patient service revenue.