Bill as Introduced

HB 1119 – AS INTRODUCED

2000 SESSION

00-2077
09/01

HOUSE BILL ***1119***

AN ACT establishing a commission to investigate health care issues.

SPONSORS: Rep. Packard, Rock 29; Rep. R. Nowe, Rock 3; Rep. Letourneau, Rock 13; Rep. Quandt, Rock 20; Rep. Martel, Hills 45

COMMITTEE: Commerce

ANALYSIS

This bill establishes a 3-year commission to investigate health care issues.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 1119 – AS INTRODUCED

00-2077
09/01

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand

AN ACT establishing a commission to investigate health care issues.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Committee Established. There is established a commission to investigate health care issues.

2 Membership and Compensation.

I. The members of the commission shall be as follows:

(a) Five members of the house of representatives, appointed by the speaker of the house.

(b) Five members of the senate, appointed by the president of the senate.

(c) Five public members, appointed by the governor.

II. Legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the committee.

3 Duties.

I. The commission shall investigate health care issues and specific problems within the health care industry. The commission shall conduct public hearings annually in at least 3 separate locations throughout the state. The commission shall gather information from consumers, representatives of the health care industry, health care providers, and representatives of the insurance industry. The commission may seek input and administrative support from the department of health and human services and the insurance department.

II. The commission shall have the same investigative powers as the general court. The commission may take evidence under oath, issue subpoenas for records, and compel testimony.

4 Chairperson; Meetings. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named house member within 45 days of the effective date of this section.

5 Reports. The committee shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the governor, and the state library in interim reports to be submitted on or before July 1, 2001 and July 1, 2002 and in a final report to be submitted on or before July 1, 2003.

6 Effective Date. This act shall take effect 60 days after its passage.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1119 Date 2-8-00

Committee Commerce

**** Please Print All Information ****

Name	Address	Phone	Representing	Pro	Con
Tom Quarles	111 Amherst St.	669-1000	N.H. HMO Assoc.		X

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 1119

BILL TITLE: establishing a commission to investigate health care issues

DATE: February 8, 2000

LOB ROOM: 302 **Time Public Hearing Called to Order:** 3 PM

Time Adjourned: 3:51 pm

(please circle if present)

Committee Members: Reps. Hunt, Francoeur, Herman, Tsiros, Belanger, McGough, Kenney, Langley, Pappas, Avery, Dalianis, DiFruscia, Marshall, M. Clark, Crosby, Russell, T. Reardon, Vachon, Taylor, Curran, Garrish and Keye

Bill Sponsors: Reps. Packard, Nowe, Letourneau, Quandt and Martel

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Packard – co-sponsor. Put in bill because of his involvement in the Womens' Issues Committee that met last summer. Feels people should be brought in. Has no objective to it being a legislative committee. Wants to hear from various people – not lobbyist when testify at many hearings.

Rep. John Hunt – stated we have 9 study committees now.

Rep. Ron Nowe – We would not be in the situation we are in now with HMO's if we had such a study overview committee. We might have anticipated existing problems we are having today.

Rep. Letourneau – 2000 seniors in Derry were dropped from HMO's with little notice – reason for co-sponsoring bill.Wants to fix broken promises by HMO's.

Rep. Lee Quandt – Direct bill from what happened in summer of 1999.Information on an independent commission he served on – received a wealth of information because they heard from average people – heard their concern – without lobbyists. Comprehensive program could be initiated in two years if the right commission is initiated.

Q: Rep. John Hunt – What could this commission achieve? We already have a study commission.

A; We cannot solve all problems piecemeal. All issues are intertwined.

Rep. Andre A. Martel - Supports bill. Concurs with Rep. Letourneau.

Dennis Martino, SEA – Supports bill. Health care costs are out of control – a comprehensive study is necessary. Gave detailed examples of problems that exist with managed-care companies. Problem with lack of doctors in the northern part of NH.

***Lori Real, Dept. of HHS** – Written testimony and analysis. Would help with fiscal note.

Rep. Martha Fuller – Requested an update in full.

Alex Feldvebel, NH DOI – Information only. Working on data now. We need better information. Work is being done to collect information at present. Wanted us to be aware of the work that is being done now and hopefully will be completed within 9 to 12 months.

***Mike Cimon, Lakes Region Orthopaedic Professional Association** – Gave examples of why a comprehensive study is necessary. Gave detailed description of problems his clinic has had. Written testimony.

Respectfully Submitted:

Jane S. Langley, Clerk

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 1119

BILL TITLE: establishing a commission to investigate health care issues

DATE: 2-8-00

LOB ROOM: 302 **Time Public Hearing Called to Order:** 3:00

Time Adjourned: 3 51

(please circle if present)

Committee Members: Reps. Hunt, Francoeur, Herman, Tsiros, Belanger, McGough, Kenney, Langley, Pappas, Avery, Dalianis, DiFruscia, Marshall, M. Clark, Crosby, Russell, T. Reardon, Vachon, Taylor, Curran, Garrish and Keye.

Bill Sponsors: Reps. Packard, Nowe, Letourneau, Quandt and Martel

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

1119

Rep Arnold: Great bill from what I appreciate in summary of 1999. Unfair on ^ Comm. He served on jud. a wealth of info. became city head from average people - head other Concerns - without lobbyist

Comprehensive Program could be initiated in 2 yrs. if the right ^ Comm. is instituted.

John Hunt ? d what this comm. could achieve - We already have a study comm.

ans: We cannot solve all problems piecemeal, and issues are intertwined.

Rep. Martel: Com Concurs with Rep Fitzmaurice.

Dennis Martin: SEA approved bill. Health Care costs are out-of-control a comprehensive Study is necessary.

Rep. Packard:
Put bill in because of his involvement in the Women's Claims Comm. that met last summer. Feels people of all walks of life should be brought in. Has no objection to it being a legislative comm. Wants to hear from various people — not lobbyists but who testify at many hearings.

Jack Hunt stated we have a study Comm. now.

Rep. Nowe: We would not be in the situation we are in now with IWMO's if we had such a study/overview Comm.; We might have another place educating problems we are having today.

Rep Letourneau: 2000 Seniors in Derry were dropped from IWMO's with little notice — reason for co-sponsoring bill. Wants to see broken promises by IWMO's.

NB

1119

3)

Martinis - con't.

Gave detailed examples of problems that exist with manage-care co's. Problem with lack of doctors in the northern part of NV.

Lori Read: Dept-NNS

Written testimony + ANALYSIS

Would ~~buy~~ help with fiscal note.

Martha F. Clark requested a up-date if feel.

Adey Feldhekel: Chr. Dept. - Info only

Working on data now.

We need better info - work is being done to collect info. at present - Wanted us to be aware of the work that is being done now + hopefully will be completed within 9-12 mo.

Reg. Differential - ? & how many recommendations made in ANALYSIS were actually implemented.

Lori Real - answered - & explained what of 36 suggestions have been implemented & what is the status of all. An up-date will be forthcoming.

Mike Simon: Sig parts held
Lake Region ORTHO P.
Some examples of why a Comprehensive study is necessary. Some detailed description of problems his clinic has had.
Written testimony

Sub-Committee Actions

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 1119

BILL TITLE: establishing a commission to investigate health care issues.

DATE: March 8, 2000

Subcommittee Members: Reps. Francoeur, Dalianis, Garrish, Clark and Manrshall

Comments and Recommendations: Concern about cross issues. Would like to cover issues under one chapter study. Will include in chapter study under HB 1183

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, (ITL), Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Clark

Seconded by Rep. Garrish

Vote: Unanimous

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Sheila T. Francoeur
Subcommittee Chairman/Clerk

Testimony

January 20, 2000
Mike Cimon
Administrator OPA
Group of 8 orthopedic surgeons
Serving the lakes region for over 35 years.

10 years

Nearly 4 years we approached LRGH with a proposal to develop an ambulatory surgery center in the Lakes Region to service our growing patient population who more and more were requiring orthopedic surgery on an outpatient or ambulatory basis.

Initially the Hospital, was eager to discuss the idea and actually took it a step further.
We historically had always worked well with the Hospital. Our practice has been the major orthopedic service provider for the Lakes Region since the mid 60's.

But things changed when the Hospital administration realized that it would not be in total control of this new center.

Threats to other surgeons who expressed a desire to participate.

Attempts to break up our own group of orthopedic surgeons by trying to individually recruit the members to work for the Hospital.

Recruiting their own Orthopedic surgeons and guaranteeing them a referral base by directing referrals from their own Hospital owned primary care doctors.

The Hospital single handedly has stopped our surgical center project in its tracks. Their team of attorney and expert consultants offered testimony at the CON Board hearings that successfully confused the members into believing that we MAY be over the threshold of $1.07 million.

The challenged our Supreme Court filing, the filed suit in Belknap County Superior Court attempting to stop our entire project requesting a "construction cease and desist", and continued to counter ever attempt we make to gain the necessary approvals to proceed with the licensing and

opening of our 1 room surgery center to serve the patients of the Orthopedic Professional Association.

But they haven't stopped there. They have openly condemned our actions in the community buy waging a major public relations campaign aimed at discrediting the physicians and adminstration of OPA.

They have amended the health insurance plan for their 1000 employees and their families, with the cooperation of Blue Cross Blue Shield, to disallow services provided in an ambulatory surgery center.

They have forced per diem and part time employees who once worked for both OPA and the Hospital to decide on one or the other – no longer can a part time employee supplement his or her hours by working for both organizations.

The have successfully eliminated competition for ambulatory surgery in the Region by delaying our project for nearly a year now with no end in sight.

All of this done and financed by public health care dollars. The concept of protecting a virtual monopoly by using public funds is disturbing.

The Doctors of OPA continue to use the Operating room facilities at LRGH and will continue to do so despite the on going battle. We will also continue to cover the emergency room 24 hours a day 365 days a year and will continue out long standing tradition of provide quality orthopedic care to the patients of the Lakes Region regardless of their ability to pay.

We strongly support HB ~~1508~~ 1119 and its attempt to investigate health care issues and practices which ultimately result in victimizing the patients and citizens of New Hampshire.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF PLANNING AND RESEARCH

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-5254/5256 FAX: 603-271-8431 TDD Access: 1-800-735-2964

Donald L. Shumway
Commissioner

Lori H. Real
Director

Testimony on House Bill 1119
House Commerce Committee
Submitted by
Lori Real, Director of Planning and Research
Department of Health and Human Services
February 8, 2000

Good afternoon, Mr. Chairman and Members of the Committee. For the record, my name is Lori Real. I serve as Director of the Office of Planning and Research, at the Department of Health and Human Services.

This bill speaks to a fundamental issue of public interest, "How do we best oversee the health care market to ensure that it is functioning properly?" With the rapid changes taking place in New Hampshire's health care market, this issue is of great concern.

The purpose of my testimony today is to advise you of the Market Analysis being conducted by the Department of Health and Human Services in conjunction with the Department of Insurance, the Attorney General's office, and the Governor's office.

By way of introduction, let me take a moment to provide some relevant background information. The Office of Planning and Research has worked with health care and social service consumers, providers, insurers, the business community, consumer groups, legislators, state and local officials, representatives of the Department of Insurance and the Attorney General's office and other state and national experts to develop *The New Hampshire Health Care System: Guidelines for Change.* As you may recall, this report contains a vision statement, values, strategies and 27 recommendations for improving New Hampshire's health care system. Let me emphasize that the degree of public input and collaboration to this work was, and is, substantial. Over a thousand New Hampshire citizens have been involved in 7 District Health Councils, 22 focus groups, 18 town meetings, symposia and reviews of interim reports. The District Health Councils continue to meet 4-5 times per year to advise in the implementation of these recommendations and to identify other health care issues to be addressed.

There are three recommendations that have specific relevance to House Bill 1119 establishing a three-year commission to investigate health care issues.

The first recommendation calls on the Department of Health and Human Services to work together with the Department of Insurance and the Office of the Attorney General, and market participants, to "jointly monitor and respond to market behavior." (*Guidelines for Change*, Recommendation 1, pp. 26-27). Upon winning a three-year grant from the Robert Wood Johnson Foundation in 1999, we embarked on steps necessary to accomplish this responsibility.

First, we have formed an interagency workgroup with the Department of Insurance, the Office of Attorney General, and the Governor's Office to review the regulatory functions of our three agencies and create a framework for improved coordination. We have begun to prepare an analysis of each agency's authority and practice as it relates to the monitoring, regulating, and financing of health care in New Hampshire. This will help us clarify the areas where we are working well together, where we can better coordinate and reinforce each other's activities, and where there are gaps in our ability to intervene that may merit the attention of the Legislature.

Second, we have been building the capacity to conduct market analysis – that is, an ongoing analysis of market structure, conduct, and performance. Our goal is to provide objective information and data that will allow all of us to assess the competitiveness of New Hampshire's health care markets and the impact of competition on costs, access, and quality. With the assistance of consulting health care economists and senior health analysts, we are in the process of developing performance indicators and designing an information system to monitor and evaluate market conditions. We will also design an ongoing data collection system. The progress of our Market Analysis work has benefited greatly from the cooperation of hospitals, health plans, community health centers, and other sectors of the health care industry.

The two tasks I have just described are complex and take time to complete. We plan to have initial work products in both areas completed by late summer of this year. These will be key building blocks for helping us determine when the market is performing well and when it is not. They will enable us to collect more relevant information and to establish clearer standards and benchmarks. They will give you better guidance in determining when State intervention is necessary, and what kind of action is appropriate.

Another recommendation in the *Guidelines for Change* is to: Develop the capacity to provide data that allows citizens to review the health status of communities and the statewide population; to understand the performance of State and market functions; and to understand the status of community concerns.

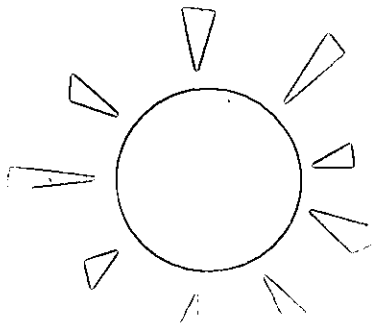
This is why the results from this Market Analysis will be made broadly available to the citizens of New Hampshire and its elected officials for consideration, debate and action. It will be presented to the Legislature, to key health care associations, to our seven District Health Councils throughout New Hampshire, to business and purchasers, and the many other stakeholders to whom this information is important. Just as we did with the results of the recent Health Insurance Coverage and Access Survey, we will conduct informational briefings. A preliminary report will be broadly distributed for public input and discussion, and individuals from the public and private sector will be convened, as appropriate, to develop policy options for consideration.

To conclude, this is work that is presently underway to strengthen New Hampshire's capacity to monitor the market and respond when necessary to protect the public interest. I hope this information will be helpful to your consideration of whether a commission with investigative powers is needed in addition to the work presently underway and the existing powers and responsibilities of the state agencies. Please note that the three-year commission created by this bill would rely on administrative support from the Department of Health and Human Services and the Insurance Department. If you should decide to go forward with this bill, I would suggest that a fiscal note be added, and I would be pleased to prepare one for our office.

Thank you for the opportunity to testify today. We look forward to keeping you apprised of our work and sharing with you the results as they become available. At this time, I would be happy to answer any questions you may have.

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THE NEW HAMPSHIRE HEALTH CARE SYSTEM



GUIDELINES FOR CHANGE

Preliminary Report • October 1998

A New Hampshire Collaborative Effort

THE NEW HAMPSHIRE HEALTH CARE SYSTEM:

GUIDELINES FOR CHANGE
Preliminary Report

September 29, 1998

Submitted to Governor Jeanne Shaheen
by the Executive Council and the
Department of Health and Human Services
Commissioner Terry L. Morton

The Honorable Raymond S. Burton
The Honorable Peter J. Spaulding
The Honorable Ruth L. Griffin
The Honorable James A. Normand
The Honorable Bernard A. Streeter, Jr.

The New Hampshire Health Care System: Guidelines for Change

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Executive Summary

In 1995, in response to changes in the health care system, the Department of Health and Human Services (DHHS) drafted legislation which was approved and signed into law that directed the Department to prepare "a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety and well-being of the citizens of New Hampshire." (RSA 126A) The Department responded by creating a statewide Health Care Planning Process - the goal of which was to develop a State Health Plan - to be conducted by the newly established Office of Planning and Research. During the past two years over a thousand New Hampshire citizens have been involved in 7 community councils, 22 focus groups, 18 town meetings, symposia [1] and reviews of the planning reports.

We wish to express our sincere gratitude to those citizens, health and social services professionals, and elected officials who participated in the health care planning and made this report (and the other reports that compose the *New Hampshire Health Plan*) possible.

(*See Acknowledgments - APPENDIX A - for a list of all who participated in the development to date of the New Hampshire Health Plan*).

The Purpose of This Report

The *New Hampshire Health Plan* consists of a series of reports (each builds upon the previous reports) that will be updated, refined and added to as the health care environment continues to change. New legislative, administrative and regulatory initiatives will result from the *Health Plan* or these initiatives will drive the development of additional studies and reports. *The New Hampshire Health Care System: Guidelines for Change* is the seventh report in this series of planning reports - all part of the *New Hampshire Health Plan* - issued by the Department.

Guidelines for Change will be widely distributed. Its intended audience(s) are those who participated in the community councils, legislators and policymakers, the business community, interested members of the public, health and social services providers and other branches of State Government.

This report has four primary goals:

- to promote improvement in the health status of the State's citizens;

[1] Symposia topics included: prioritizing health care needs, the role of the community, long term care and health and social service networks.

- to provide a framework for policy makers to manage change within the health care system, balancing the roles of the State, the Community, and the Market;

- to offer and promote strategies for action which respond to the need for comprehensive statewide health reform; and

- to promote and encourage broad participation from citizens, providers, purchasers and public officials.

(See also Health Care Reform in New Hampshire: 1986 - 1998 - APPENDIX B - for a concise history of past and present New Hampshire initiatives in health care reform, including events that led to the Health Care Planning Process).

The Structure of This Report

The *New Hampshire Health Care System: Guidelines for Change* is divided into the following sections:

Executive Summary
Introduction
I. New Hampshire's Health Vision, Values and Goals
II. Strategies for State Action
III. Appendix

The Definition of Health

The participants in the Health Care Planning Process and the Department of Health and Human Services decided that any consideration of the health care system should be based on a positive definition of the terms "health" and "health care." Health is not merely the absence of illness; it is the presence of well-being or the realization of potential. Health care should not be understood merely as treatment for illness; it should include necessary and appropriate services, medical, social or other, that is intended to promote the highest possible level of function and independence for an individual. Health care should address the whole person. Its goal should include physical, emotional and spiritual growth, satisfaction and fulfillment - the flourishing of the individual.

For these reasons, the term "health," as used herein, will have the same definition as that put forth by the World Health Organization:

> "A state of complete well-being, physical, social and mental, and not merely the absence of disease or infirmity."

Vision

In order to ensure that New Hampshire residents enjoy the highest quality of life attainable, the *New Hampshire Health Plan* will promote access for everyone to necessary and appropriate health and social services.

Health System Values

In order to find out what values New Hampshire citizens held most important regarding the health care system, the Office of Planning and Research used two sources. The first and most significant source was the extensive set of discussion groups that were conducted throughout the State.[2] The second source was derived from work conducted by the seven District Councils. The participants in each District Council were asked to discuss and agree upon a set of statements describing the functional characteristics of an ideal health care delivery system by answering the question: What would an ideal health care delivery system do?

The purpose was to elicit the expression of core values that could be used to set requirements for the health care system in the future.[3] As part of this endeavor, questions were presented to the discussion groups:

- What do you consider to be essential in any health care system?
- What do you consider to be intolerable?

---

[2] Twenty-two discussion groups served as proxies for the State's citizens. The groups ranged in size from 6 to 40 members. Some of these groups consisted of individuals with similar backgrounds or concerns (eg, hospital administrators or individuals with disabilities) or mixed gatherings of citizens representing the concerns of different provider groups, business, government and citizens (eg, the seven district councils.) The participants were not randomly selected. They were either members of groups; recommended by individuals within the Department of Health and Human Services or the Executive Councilors; or selected by the Executive Councilors. The goal was to elicit a range of different perspectives from people actively engaged in the provision, use and purchase of health care.

[3] In 1993, the New Hampshire legislature engaged in a similar exercise and passed a resolution stating principles upon which a universal health care program in New Hampshire should be based. They are as follows:

1. Universality: all individuals in the state have a right to high quality, comprehensive health care regardless of employment status, health status, gender, age, personal resources, or geographic location.
2. Accessibility: everyone should have equal access to health care providers and to the information necessary to make informed choices.
3. Comprehensiveness: all necessary health care is covered, with an emphasis on preventive care and the promotion of wellness.
4. Affordability: health care must be affordable for all individuals in the state. Costs must be distributed equitably, based on ability to pay.
5. Cost Control: there must be cost control and capacity containment.
6. Accountability: individually and collectively, directly and through elected representatives, all individuals must be empowered to influence and improve the health care system continually.

The five core values common to both of these sources are listed in Table 1.

Table 1

New Hampshire Health System Values

1. **Every New Hampshire resident will have access to necessary health care services regardless of individual circumstances.**
2. **The health care system will be based on desired health outcomes as determined by well-defined indicators for measuring health.**
3. **The health care system will emphasize quality of care and focus on managing costs.**
4. **Health care consumers will be empowered and assume primary responsibility for their health and for the care they receive.**
5. **Communities will play a role in the organization and integration of health systems and in the delivery of health care services.**

Health Goals

After an extensive discussion of the definition of health and the indicators by which health status ought to be measured, the members of the District Councils were asked to articulate a vision and goals statement for the health status of New Hampshire citizens. The result was the following statement:

> To ensure that New Hampshire residents will enjoy the highest quality of life attainable, the New Hampshire Health Care Plan will promote universal access to necessary and appropriate health and social services. The Health Care Plan will be a strategy for achieving the Health Status Goals (see Table 2). The Health Status Indicators that are associated with the goals will provide benchmarks for measuring New Hampshire's progress in achieving health and well-being. The Plan, the Goals, and the Indicators will be developed with input from hundreds of New Hampshire citizens.

Table 2

Health Status Goals

1. **New Hampshire residents will live with independence and satisfaction as contributing members of their communities.**
2. **New Hampshire residents will live with a minimum of disease and disability.**
3. **New Hampshire residents will live in safe and supportive homes and communities.**
4. **New Hampshire residents will live free of environmental hazards.**
5. **New Hampshire residents will have the educational and economic opportunities they need to realize their full potential.**
6. **New Hampshire residents will choose behaviors which contribute to health and well-being.**

Strategies

The strategies for state action focus specifically on the health care system. Four primary strategies based on the vision and goals are outlined in this section:

A. promoting access to health care coverage while managing costs;

B. protecting and empowering consumers;

C. re-defining public health; and

D. partnering with communities.

There are a total of 27 recommendations (see Appendix C on page 90) for implementing these strategies. Each recommendation is followed by a brief explanation. Some of the

recommendations can be prioritized and achieved under existing administrative authority. Others will require legislative deliberation and action.

A. **Promoting Access to Health Care Coverage While Managing Costs** describes the challenge in addressing the problem of the uninsured through a voluntary approach. Any efforts must be coordinated with other health reforms so as to avoid expending resources on initiatives that fail to eliminate the root of the problem or that merely shift the problem from one area to another. The strategies and initiatives outlined here are designed to improve access to health insurance coverage and control costs through incremental reforms that address all aspects of the health insurance market and that are coordinated to achieve maximum combined effect.

   This strategy has three components:

   1. pursue continued insurance market reforms to enhance competition and discourage risk selection (eg, interagency monitoring of the health care market, monitoring the number of uninsured, standardized benefit packages, and risk adjustment);

   2. organize purchasing activities to enhance competition (eg, a small business health insurance purchasing alliance); and

   3. subsidize private market coverage and support safety net providers and delivery structures (eg, a two phase expansion of health insurance coverage, definition of the scope and funding sources of safety net services, coordination of health-related non-medical services with medical care, review of the role of Certificate of Need, and establishment of standards of adequacy for the delivery system).

B. **Protecting and Empowering Consumers** describes how this could be accomplished in a market-driven health care environment. The market functions best when there is a choice of products and providers and sufficient information for consumers to make informed decisions.

   Recently released national data shows that four out of five employers who sponsor health insurance offer only one plan to their employees. The health care industry in New Hampshire is undergoing an historic transformation as more people enroll in HMOs and other types of managed care plans. The State saw a 25% increase in underwritten managed care enrollment between 1994 and 1995, and an increase of 18% between 1995 and 1996. In the small group market that shift has been dramatic - during 1998 HMO enrollment for this population is expected to reach 80%. CIGNA/HealthSource and Blue Cross/Blue Shield, who purchased Matthew Thornton in 1997 accounted for 77% of HMO enrollees in 1996.

Most states, including New Hampshire, do not have information systems capable of monitoring or supporting health reform. Funding, data comparability, and cooperation of providers and insurers will be issues the State must address if it is to construct a viable health care information system.

This strategy has four components:

1. establish a system for conflict resolution between consumers and providers with their health plans (eg, mediation and consumer hotline);

2. assure the quality of care (eg, organization/collaboration of interested parties and a coordinated State monitoring policy);

3. develop a State information infrastructure (eg, review of health status, State and market functions, community concerns, and private development of information); and

4. assure the solvency of risk-bearing entities (eg, licensure of risk-bearing entities according to the number of covered lives, structure and percent risk assumed, guidelines for transferring risk from one entity to another and self-insured plans).

C. **Re-Defining Public Health in the Evolving System** examines the traditional public health roles within a managed care delivery system.

In 1996, 39% of New Hampshire's population was enrolled in HMOs (includes underwritten managed care and self-funded business). The health status of enrollees in an HMO becomes a critical determinant to the financial success of an HMO. As the portion of the population enrolled in HMOs increases, the domain of HMOs and public health may overlap. Since the State's residents are rapidly choosing to receive care from two HMOs, these HMOs can - and some would argue should - offer some population-based services that were traditionally provided by public health. In addition, these HMOs may have to perform some of the public health evaluations of the effectiveness, accessibility and quality of personal and population-based services.

This strategy has three components:

1. redefine public health;

2. determine the impact that private and community reorganization of health care services have on public health; and

3. determine which public health functions should remain, be expanded, altered or eliminated in light of private and community reorganization of health care services.

In the new health care system, the resources allocated to public health services may be inadequate or excessive depending upon how public health roles are altered.

D. Partnering with Communities addresses how and why the voice and needs of the community should be a part of the new health care system. The discussions during the planning work raised two basic questions about both communities and the State's involvement:

- What is a community - what is it that the State should be listening to and promoting?
- Why should the State support community involvement in the health care system?

When these questions are fully answered through the planning work, the State can begin to consider how it should assist communities and what form the assistance should take. The State can also determine what it can expect from communities: the way they can balance and augment the actions of the State and the market. This will also allow the State to work with communities to clarify expectations for private entities that claim a community role. For example, non-profit hospitals are described as community organizations that provide community benefits. In return, these institutions do not pay taxes; that is, they receive a public subsidy. However, neither the State or any independent body representing communities define the community benefits that non-profits should be providing.

This strategy has two components:

1. sustain community involvement in health care delivery; and
2. define and protect community benefits.

Next Steps

The planning process does not end with the production of this report. This report is not done. It represents a "preliminary report" that incorporates the review of the participants in the planning work to date. Additional review and revision will be necessary. Much work remains to broaden participation in the coming months, particularly to gain the perspectives of the business, legislative, and market communities. Further involvement of other State agencies will also be sought.

Determination of the priorities, action steps, and stages of implementation to achieve the strategies (*Strategies for State Action*) will be done in concert with all stakeholders in keeping with the participatory and iterative nature of the planning process. This report proposes the structure(s) that will allow for continuous and ongoing planning with participation of communities, the State, and the market. It is not a detailed blueprint of how the New Hampshire health care system will develop. Health planning in New Hampshire has become a verb instead of a noun. Instead of a detailed blueprint, it has evolved to a continuous process that permits and directs movement towards general goals.

At this point, some of the recommendations are being accomplished in the short-term; others will be dependent on actions that will necessitate a long-term view. Priorities will need to be set in concert with other interested stakeholders. Decisions will need to be made as to which recommendations can be achieved via administrative, regulatory or legislative action.

The recommendations can only be realized with an understanding of their financial implications. The next phase of work must include:

1. what we spend today on healthcare and where the money is distributed,
2. a health care budget for the future, and
3. the cost and benefits of implementing the recommendations.

The same open and collaborative course that brought the Health Care Planning Process to this point will be used with work that remains to be done. Input from a broader audience will help refine and improve the process and the strategies.

The *Guidelines for Change* represents the culmination of one phase of the health planning work. At the same time, it also represents the beginning of the next phase.

Introduction

Dynamic Planning For A System In Transition

Guidelines for Change proposes processes and structures that New Hampshire should use to make health planning a continuous initiative and it also allows the State to respond to and manage the rapid changes in the health care environment. It is not a traditional health plan that lays out the number of providers and facilities necessary with a step-by-step process on how to get there.

Massive market changes and the corresponding reactions to those changes are re-aligning, re-structuring and consolidating all that was once familiar in the organization and financing of health care. These forces are driven by regional and national developments that go far beyond the control of State government. Amidst these massive changes in the health care system, traditional health planning has become less useful. No single individual or group can offer a detailed blueprint of the ideal health care system. Change has forced a reconsideration of the nature of health planning, as the organization and delivery of health care services are being recast on what seems like a daily basis.

The changes in the way health care services are delivered are being matched by the changes in the organization of health care providers. The rapid rate of mergers of existing health plans and the equally rapid dissolution and creation of new health care organizations are altering the delivery system. Perhaps the most compelling factor that prevents simply supporting the status quo is that the status quo is rapidly disappearing. The organizational arrangements that held the status quo in place supported a system characterized by independent providers caring for patients who in turn had an unrestricted choice of physician or hospital. The financial arrangements reimbursed care on a fee-for-service basis through employer-based indemnity insurance. These organizational and financial arrangements are rapidly disappearing. The world of national and regional provider systems, constrained consumer choice, capitation and managed care are upon us.

For New Hampshire the question is not how to preserve the past but how to adapt to and direct the changes that are unfolding. How can we assure the system in transition continues to promote improvement in the health status of New Hampshire's citizens? The planning work engaged the citizenry in answering that question.

Citizen Participation in Action

The New Hampshire health care planning work began with the development of health status indicators and goals for New Hampshire's health care system, moved on to detailed discussions on the delivery system, and finally, to summarizing the issues that must be addressed and proposing recommendations.

From the outset of the planning work in the late fall of 1995, a commitment was made to citizen participation and a cautious application of traditional planning techniques. Given the changes in the world of health care, the planning efforts were targeted on:

- **The Requirements**. Instead of dictating how all of the parts should fit together, the health planning focused on the participants' requirements of a system.

- **Honoring the Needs of the State, Communities and the Market.** The question was how best to create a planning system that expressed and balanced the needs and concerns generated from each perspective.

- **Strategic Framework.** The planning focused on a strategic framework for the entire population versus programmatic or categorical recommendations for specific segments of the population.

- **Decentralized Decision-Making.** The community council meetings were held in various regions within the State rather than in Concord. Health care has been always been a local affair, and a broad process for changing the health care system should take place as close as possible to the communities that will be affected by the changes.

- **Inductive Reasoning.** In keeping with the belief in citizen participation and collaboration, the planning relied upon working from the specific and concrete to the general and abstract. Before individuals were asked to recommend general goals for the health care system, they were asked to propose concrete examples of health. These indicators of health included comments such as: "My cancer is in remission." "My child can go to a safe day care center." "My grandfather has transportation to a local senior center."

- **Iterative.** Planning was viewed as a process that should be continuously revised as the health care environment changes. The *New Hampshire Health Plan* would be built upon previous work (eg, reports and legislative initiatives).

This effort was accomplished through an open and collaborative process that relied heavily upon citizen participation and inter-governmental involvement. The Executive Councilors worked with the Department of Health and Human Services to create seven community councils called District Councils throughout the State with diverse representation of more than 250 citizens. Each of these District Councils defined health care problems and offered many of the solutions included within this report. The District Councils also convened town meetings in which more than 600 New Hampshire residents participated. More than 50 professional and consumer groups were consulted on an ongoing basis. Twenty-two focus groups examined the values that should be preserved in the health care system and the appropriate designation of roles and responsibilities within the State. Representatives from the Governor's Office, the Department of Education, the

Department of Insurance, the Department of Environmental Services, and the Attorney General's Office also participated in this effort.

The Office of Planning and Research also relied upon information in the literature on health care reform and on precedents from other States. National health care experts and policy makers from other states were consulted as to what has and has not worked. Some of this information was disseminated through reports and some through a series of symposia on a diverse range of topics. Finally, the analysis and resulting strategies presented in this seventh report were critiqued by panels of state and national experts.

Health Care Planning Accomplishments

This report is based upon a series of reports (which together comprise the *New Hampshire Health Plan*) that were developed through broad public input and discussion. They include:

The Elements of an Ideal Health Care Delivery System. Participants at the first District Council meetings were asked to describe the "ideal health care system". The results of that discussion are summarized in this report.

An Inventory of Health Status Indicators. These indicators can be used to monitor health changes in the general population, the performance of the health care system, the health status of the Department's clients, and the performance of providers caring for the Department's clients. They represent the broad definition of health that encompasses physical, mental, social, and economic well being.

New Hampshire's Health Status Goals. After the Health Status Indicators had been developed, the District Councils established six broad goals to guide its work. Health Status Indicators will be aligned under the Goals and targets will be identified both at the State and community levels - with an eye towards the many determinants of health.

Health Planning, Values and Preferences. This report reviews the responses of 22 focus groups to the questions: "What do you see as essential in any future health care system?" and "What do you find intolerable?"

The State, Communities, and Individuals: Roles and Responsibilities in New Hampshire's Health Care System. This report outlines the focus groups' identification of the major functions within the health care system and their assignment of these functions to various sectors within New Hampshire.

New Hampshire Network Survey Report. This report is a review of 29 health and social service networks that have been developed or are in the process of being created in New Hampshire.

Planning and the Health Care System: A Question of Balance. This serves as the resource document. It provides the background information that led to the recommendations, a survey of the literature on health care reform and its effects on the current delivery system, and precedent from other states. It also includes some data and examples from around the State that illustrate how New Hampshire is responding to the changing health care system.

Consumer Report. In order to inform the general public, a "consumer friendly" version of the seventh report was developed. The reasons for the creation of a Health Plan and key consumer issues are presented in an easy-to-read booklet format.

Many of these reports - including *The New Hampshire Health Care System: Guidelines for Change* - will be accessible through the Department's web site:
http://www.state.nh.us/dhhs/deptlinks.htm

They can also be requested from the New Hampshire Department of Health and Human Services, Office of Planning and Research at:

6 Hazen Drive
Concord, NH 03301
Phone number: (603) 271-5254
FAX number: (603) 271-4232

Public comments on this report are encouraged, and they may be directed to the above address.

I. New Hampshire's Health Vision, Values and Goals

A guide for change in the health care system will represent the interests of New Hampshire residents only if it is built on an accurate assessment of New Hampshire's vision and values regarding health. For this reason, the health planning process began with consideration of the following questions. What is the best way to use and to understand the terms "health" and "health care"? What are the values that New Hampshire residents hold most important regarding the health care system?

The Definition of "Health"

The participants in the Health Care Planning Process and the Department of Health and Human Services decided that any consideration of the health care system should be based on a positive definition of the terms "health" and "health care." Health is not merely the absence of illness; it is the presence of well-being or the realization of potential. Health care should not be understood merely as treatment for illness; it should include necessary and appropriate services, medical, social or other, that is intended to promote the highest possible level of function and independence for an individual. Health care should address the whole person. Its goal should include physical, emotional and spiritual growth, satisfaction and fulfillment - the flourishing of the individual.

For these reasons, the term "health," as used herein, will have the same definition as that put forth by the World Health Organization:

> "A state of complete well-being, physical, social and mental, and not merely the absence of disease or infirmity."

Correspondingly, the term "health care," will mean:

> "Services, medical, social or other, the primary purpose of which is to promote the highest possible level of function and independence for an individual."

Vision

In order to ensure that New Hampshire residents enjoy the highest quality of life attainable, the *New Hampshire Health Plan* will promote access for everyone to necessary and appropriate health and social services.

Health System Values

In order to find out what values New Hampshire residents held most important regarding the health care system, the Office of Planning and Research used two sources. The first and most significant source was the extensive set of discussion groups that were

conducted throughout the State.[1] The second source was derived from work conducted by the seven District Councils. The participants in each District Council were asked to discuss and agree upon a set of statements describing the functional characteristics of an ideal health care delivery system by answering the question: What would an ideal health care delivery system do?

The purpose was to elicit the expression of core values that could be used to set requirements for the health care system in the future.[2] As part of this endeavor, two questions were presented to the discussion groups:

- What do you consider to be essential in any health care system?
- What do you consider to be intolerable?

The five core values common to both of these sources are listed in Table 1 and described following the table.

[1] Twenty-two discussion groups served as proxies for the State's residents. The groups ranged in size from 6 to 40 members. Some of these groups consisted of individuals with similar backgrounds or concerns (eg, hospital administrators or individuals with disabilities) or mixed gatherings of residents representing the concerns of different provider groups, business, government and residents (eg, the seven district councils.) The participants were not randomly selected. They were either members of groups; recommended by individuals within the Department of Health and Human Services or the Executive Counselors; or selected by the Executive Counselors. The goal was to elicit a range of different perspectives from people actively engaged in the provision, use and purchase of health care.

[2] In 1993, the New Hampshire legislature engaged in a similar exercise and passed a resolution stating principles upon which a universal health care program in New Hampshire should be based. They are as follows:

1. Universality: all individuals in the state have a right to high quality, comprehensive health care regardless of employment status, health status, gender, age, personal resources, or geographic location.
2. Accessibility: everyone should have equal access to health care providers and to the information necessary to make informed choices.
3. Comprehensiveness: all necessary health care is covered, with an emphasis on preventive care and the promotion of wellness.
4. Affordability: health care must be affordable for all individuals in the State. Costs must be distributed equitably, based on ability to pay.
5. Cost Control: there must be cost control and capacity containment.
6. Accountability: individually and collectively, directly and through elected representatives, all individuals must be empowered to influence and improve the health care system continually.

Table 1

New Hampshire Health System Values

1. **Every New Hampshire resident will have access to necessary health care services regardless of individual circumstances.**
2. **The health care system will be based on desired health outcomes as determined by well-defined indicators for measuring health.**
3. **The health care system will emphasize quality of care and focus on managing costs.**
4. **Health care consumers will be empowered and assume primary responsibility for their health and for the care they receive.**
5. **Communities will play a role in the organization and integration of health systems and in the delivery of health care services.**

1. **Every New Hampshire resident will have access to *necessary* health care services regardless of individual circumstance.**

Access to care should not depend on ability to pay, employment status, age, gender, geographic location, or any factor other than a determination of individual need. This means, in part, that services must be affordable to everyone. Affordability, in this sense, means using subsidies to adjust payment for care (either premiums or direct contributions for care) based on income.

Universal access requires, among other things, the existence of a basic or standard benefit package that is available and (through targeted subsidies) affordable to everyone and that is sufficiently comprehensive to cover all necessary care. The basic or standard package may need to be customized for the populations that are being served (eg, children need a different set of services than adults and persons with disabilities often have special needs for medical equipment and pharmaceuticals).

Universal access to necessary care is not simply a matter of insurance coverage, even if such coverage is adjusted to the special needs of different populations. Needed services must be available as well as affordable, particularly for persons in rural areas and some underserved urban areas and for those with long term or high cost needs. Access exists

only when an appropriate mix of providers is present in the community. This includes providers of non-medical, health related services, such as respite services[3] or transportation assistance, that address the needs of the individual and the family. Some services are not (at least at this stage of the health care system's development) amenable to managed care or the operation of the insurance marketplace. Assuring the availability and affordability of such services is a matter of assuring the existence of a safety net of community-based social service and health care providers.

2. The health care system will be based on desired health *outcomes* as determined by well-defined indicators for measuring health.

The transition from understanding of health care as essentially treating illness to health care as promoting well-being leads to an increased emphasis on health outcomes. The health care system should be evaluated and shaped on the basis of desired health outcomes.[4] Health Status Indicators and Health Status Goals should play an important role in developing guidelines for change in the health care system (see pages 14-16). This means an increased emphasis should be placed on prevention and wellness. Currently, many care systems are illness-oriented and focused solely on the delivery of medical services. By making better use of public health expertise, by restructuring incentives to providers, insurers, payers and consumers, and by adjusting the criteria for allocating resources, the health care system could be designed to promote desired health outcomes as determined by well-defined indicators for measuring health.

3. The health care system will emphasize *quality of care* and focus on *managing costs*.

In the rapidly evolving and increasingly bottom-line oriented health care system, there should be greater emphasis on preserving and assuring adequate quality of care. Managed care should be monitored and incentives used to ensure that it promotes the best care and not just the best price. If managed care case managers are able to limit choice of provider or services, they should be subject to the same quality of care standards as are health care providers. Case management should not be carried out in such a way as to harm the therapeutic relationship between the provider and the patient. With the advent of managed care, the degree to which health care services are consumer sensitive and consumer responsive ought to increase rather than decrease.

The member of a health plan must play a prominent role in assessing and improving the quality of care. Consumers should have access to improved processes for seeking resolution to problems. Consumer satisfaction and functional[5] outcomes should receive equal weight with evaluations of technical competency and clinical procedures. Patients

[3] Respite services are when professional care is provided in place of family care for an individual living at home; it might consist of placement in an institution or paid help at home.

[4] Health outcomes refers to the patient health status and satisfaction resulting from specific medical and health interventions.

[5] Functional outcomes refers to the ability to perform regular activities of daily living.

must be treated with dignity and respect and in a manner that is sensitive to cultural and socioeconomic differences. Consumers should be given a more active role in improving the quality of services by allowing them to articulate an assessment of the care they received (or did not receive as promised in their contract) and holding providers and insurers accountable to respond to that assessment.

4. Health care consumers will be *empowered* and assume primary *responsibility* for their health and for the care they receive.

Consumers should have sufficient information to exercise informed choice regarding their own health. Choice, in this context, is defined as the ability to choose (or retain) a provider as well as the exercise of personal autonomy - ie, the ability to control what services one receives.

Consumers need improved information and education in order to make the exercise of choice meaningful, to promote individual responsibility, and to improve the quality of care. The quality of the lives of citizens could be improved if they had better information and training about the impact of their behavior on their lives (smoking, drinking, diet, exercise, drugs, risky sexual behavior, etc.) and better guidance and assistance for self-help. In addition, the system could be used more wisely and consumers would be better informed if they knew how to assess the quality of providers or health plans that were in their community (eg, if "report cards" existed that compared health plans or providers on similar quality standards). Consumers would also have a much better experience with the health care system if they understood how the system should be used, what the provider responsibilities are and what the patient's responsibilities are. This is an essential step in promoting individual responsibility.

The individual also plays an important role in improving the viability of the current market-based approach to managing costs. Individuals should have better access to information about the cost of their health care decisions. All individuals should pay something towards the cost of their care, if only a small amount.[6]

5. *Communities* will play a role in the organization and integration of health systems and in the delivery of health care services.

The term "communities" can be defined in two ways: as a group of residents in a specific geographic area with distinct regional characteristics, and as groups of individuals (usually statewide) who have, or are relatives of individuals who have, specific physical or mental conditions. In either case, communities should play a strong role in identifying community needs and ensuring access.

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[6] For very low income persons, however, the contribution must be truly nominal in order to prevent it from acting as a barrier to needed care. Even a five or ten dollar co-payment can be a barrier to needed care for the very poor.

Market-based solutions should not be pursued at the expense of communities. Community needs and preferences should be built into market solutions. The increasing consolidation of the market (eg, such as the merger of two health plans) should not result in the neglect of the needs of individual communities. (Some participants in the Health Care Planning Process wanted community-based institutions and providers with a historical commitment of service to a locality to be given preference to competitors from outside the area.) Finally, cooperative solutions developed by consumers and local providers should be preserved and protected - eg, the community care system for persons with developmental disabilities.

Communities are also essential to the task of improving the integration and coordination of care. Savings could accrue if the duplication of efforts among providers could be reduced and the coordination of care within and between medical, mental health and non-medical health-related service providers could be increased. Administrative costs could be reduced, particularly if there was a streamlining of programmatic requirements from state and federal government. This integration and coordination must take place primarily at the community level. This is particularly true with long term care and services for the chronically ill, where there is a need to integrate a diverse set of community resources to support individuals and families in the community with a continuum of care.

This emphasis on community should be tempered by the fact that health care decisions must remain personal decisions. Not all localities have the expertise to make policy decisions about health care and some participants feared that communities might punish unpopular members.

While not an explicitly stated value, a common theme that ran through the planning work and strategy development was that the effort to control health care costs through private markets should be informed by consideration of the limits of markets.

The cost of health care is a barrier that needs to be overcome in order to achieve universal access to care. The theoretical assumption behind the current trend toward mergers, networks and managed care is that the cost barrier can be overcome through a market-based approach. However, the market, especially in the context of health care, is not a panacea.

First, a purely market-based approach to health care would never reach universal access. Markets ration by the ability of individuals to pay for goods and services, and there will always be many individuals who cannot afford to pay for the health care that they need. It is not appropriate to ration health care based on ability to pay. Second, steps need to be taken to improve the operation of the health care market before there can be an effective market solution. For example, consumers and purchasers must be empowered with information and choice in order to create meaningful competition based on the value of the services provided. Similarly, incentives to providers, insurers, purchasers and consumers need to be structured to promote cost effective practices and systems and to

maintain an appropriate balance between investment in high-tech care and providing for basic health needs. Third, a market-based solution may never be appropriate for some populations with special needs. Finally, community needs, community-based institutions and providers, and community-based cooperative solutions should be considered with market solutions.

Generally, it is the role of the state to monitor the health care market and to ensure that it operates in a manner that is consistent with the interests of consumers. In this regard, the State should make a special effort to streamline and standardize regulatory requirements and information systems to eliminate duplication.

Health Goals

After an extensive discussion of the definition of health and the indicators by which health status ought to be measured, the members of the District Councils were asked to articulate a vision and goals statement for the health status of New Hampshire citizens. The result was the following statement.

New Hampshire Health Status Vision and Goals

> To ensure that New Hampshire residents will enjoy the highest quality of life attainable, **the New Hampshire Health Care Plan will promote universal access to necessary and appropriate health and social services.** The Health Care Plan will be a strategy for achieving the Health Status Goals (see Table 2). The Health Status Indicators that are associated with the goals will provide benchmarks for measuring New Hampshire's progress in achieving health and well-being. The Plan, the Goals, and the Indicators will be developed with input from hundreds of New Hampshire citizens.

Table 2

Health Status Goals

1. **New Hampshire residents will live with independence and satisfaction as contributing members of their communities.**

2. **New Hampshire residents will live with a minimum of disease and disability.**

3. **New Hampshire residents will live in safe and supportive homes and communities.**

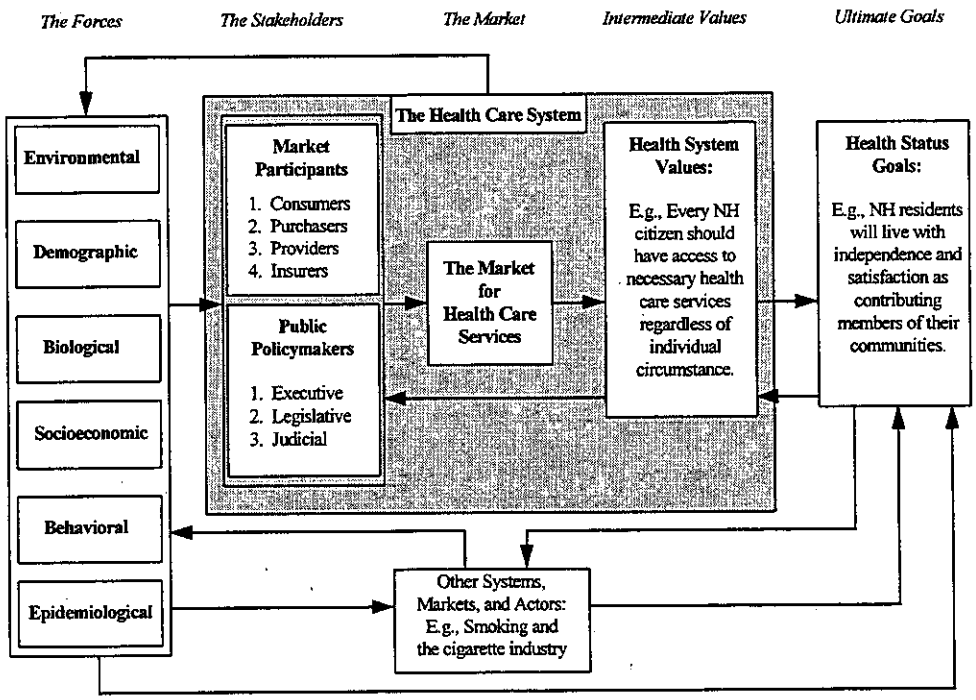
4. **New Hampshire residents will live free of environmental hazards.**

5. **New Hampshire residents will have the educational and economic opportunities they need to realize their full potential.**

6. **New Hampshire residents will choose behaviors which contribute to health and well-being.**

The definition of "health" adopted for the health planning work describes a state of complete physical, mental, and social well-being. The supporting *Health Status Goals* address a broad array of factors affecting the quality of life in New Hampshire. It becomes clear that the health status of the population or of an individual is only partially determined by what we traditionally think of as the health care system - the sum total of all people, institutions, relationships, laws, regulations, customs and practices involved in the financing and delivery of health care. Factors such as the physical environment, education, income, and lifestyle are more determinative of health status than the health care system. A more complete perspective on the impact of the health care system and other forces on health status is suggested in Figure 1.[7]

Figure 1 Health-Related Forces and the Health Care System



Health is influenced in the first instance by environmental, demographic, socioeconomic, behavioral, cultural, and epidemiological forces. Many of these forces affect a society's health in ways that are largely independent of the health care system. One example is the expanding elderly population. Although the health care system may respond to this demographic change by developing new approaches to health care that address the special

[7] This figure is adapted from a model proposed by J.D. Wilkerson, K.J. Devers, and R.S. Given in *Competitive Managed Care: The Emerging Health Care System*. Jossey-Bass Publishers, San Francisco, CA, 1997, p. 361.

needs of this group, it is not likely that the system will be able to prevent an overall increase in the incidence of age-related illness. The effects of these forces will also depend on the responses of other systems, markets and other players that are not directly involved in the health care system. For example, cigarette manufacturers may opt to conceal information about the harmful effects of smoking and promote smoking among young persons as a behavioral norm with disastrous consequences for public health.

It is clear that even if the health system values described above were completely actualized, this would not be sufficient to ensure the fulfillment of the health status goals. The health system values are merely intermediate values and not ends in themselves. They are valued as means for the efficient and equitable promotion of the ultimate goals for health status.

For these reasons, a comprehensive plan for achieving the health status goals should address a broad range of values and recommendations involving every system, institution, market, or player that is significantly related to any of the forces affecting health status.

Taking the Measure of New Hampshire's Health and Well-Being

The New Hampshire health care planning work began in the late fall of 1995 with the development of the *Health Status Indicator Inventory*. Hundreds of consumers, health and social services providers, advocates and officials from 40 states were interviewed. Before individuals were asked to recommend general goals for the health care system, they were asked to propose concrete examples of health. From the outset, people defined health broadly and did not think solely in terms of medical care.

The initial draft of the *Health Status Indicator Inventory* was reviewed by most of the contributors, plus units within the Department of Health and Human Services, the District Councils and anyone else who requested a copy. Additional revisions were made with particular attention to selected populations (eg, substance abusers, elders, developmentally disabled and others). While the *Health Status Indicator Inventory* was being revised, the District Councils assisted the Department in developing *New Hampshire's Health Status Goals* (that were listed above). Next, the District Council members used the *Health Status Indicator Inventory* to identify the areas that should be included under each *Health Status Goal*. The *Inventory* contains 284 indicators; the goals and their indicator areas are listed below.

1. New Hampshire residents will live with independence and satisfaction as contributing members of their communities.

- Ability for self-determined treatment and management
- Transportation
- Child care
- Housing tenure or ownership
- Respite care
- Community participation
- Reported sense of well-being

- Level of insurance
- Employment rate
- Attendant care
- Access/availability of services
- Independent skills instruction

2. New Hampshire residents will live with a minimum of disease and disability.

- Immunization rates
- Cancer incidence
- Death rates
- Prevalence of disability
- Arthritis, diabetes
- Days lost from work
- Dental health
- Prevalence of mental illness
- Prenatal care
- Neonatal health
- Infectious disease
- Primary care access
- Behavioral health access
- Substance abuse and alcohol
- Chronic disease incidence
- Disease outbreaks
- Prevention services

3. New Hampshire residents will live in safe and supportive homes and communities.

- Violence and abuse; domestic assault
- School drop-outs
- Crime rate
- Exploitation and neglect
- Teen birth rate
- Adequate housing
- Unintentional injuries
- Accessible public facilities
- Placement outside community
- Children who move during the school year
- Homelessness
- Divorce rate
- Child support enforcement
- Senior fraud

4. New Hampshire residents will live free of environmental hazards.

- Clean air
- Fluoride
- Lead
- Clean water
- Occupational hazards
- Workplace injuries
- Disposal of toxic waste
- Asbestos
- Safe food
- Noise

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1999 ERRATA SHEET
for
The New Hampshire Health Care System: Guidelines for Change

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Goal 4. New Hampshire residents will live free of environmental hazards.

The inclusion of fluoride as an indicator area under Goal 4 is intended to support the presence of fluoride in drinking water supplies, either naturally occurring or introduced, as a means of improving the oral health of the population. It is not considered an adverse environmental condition.

Lori Real, Director
Office of Planning & Research

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5. **New Hampshire residents will have the educational and economic opportunities they need to realize their full potential.**

- Special education
- Level of education
- Enrichment activities
- Employment rate
- Income levels
- Job availability
- Job training opportunities
- School drop-out
- Early childhood development
- Job satisfaction
- Scholarship/financial assistance
- Adult education
- Employee/family benefits

6. **New Hampshire residents will choose behaviors which contribute to health and well-being.**

- Smoking
- Seatbelts
- Substance abuse
- HIV/STDs
- Physical fitness
- Nutrition
- Helmet use
- DWI
- Auto crash rates
- Water safety
- Teen birth rate
- Handguns
- School health education

As a continuation of the health planning work, the Department will develop public-private partnerships to consider three issues:

- Which indicators should be included among the "key" indicators (a short list of important indicators)?
- What strategies would permit and foster the development of readily available data for the health status indicators?
- What strategies can be employed to collect data that is not presently available?

The Health Care System

The following strategies for State[8] action focus primarily on the medical services component of the health care system. There are a number of reasons for this approach at this stage of the development of the *New Hampshire Health Plan.*

The health care system continues to evolve rapidly in response to both private and public initiatives.[9] Mergers and alliances among providers, insurers, and purchasers are occurring at a breathtaking pace.[10] The Medicare and Medicaid programs are moving toward privatization, and health insurance reforms continue to be the frequent subject of legislation on both the state and national levels. In this environment, it is prudent to focus health planning resources on identifying goals and guidelines that can be used to manage this rapid change.

There is a practical advantage to focusing initially on the health care system in that its effects on health status are more immediate. Although factors such as education and income appear to have much larger effects on health status than does access to health care,[11] the benefits of an investment in heart surgery, for example, are immediate and measurable, while the benefits of a similar investment in college scholarships for low-income youths would be difficult to measure.[12] Even though the aggregate health benefits to society of the latter might be larger, they would be more difficult to isolate and to justify the investment.

Considerations of equity and social justice also tend to focus attention on the health care system. Many participants in the Health Care Planning Process felt that the current health care system fails badly on this scale. For New Hampshire's uninsured citizens, it fails to fulfill the first health value - that every New Hampshire citizen should have access to necessary health care services regardless of ability to pay.

Other components of the health care system (as defined on page 13) are addressed in :

- determination of a health insurance benefit package (Recommendation 3) (Page 27).
- determination of the scope, funding sources and providers of safety net services (Recommendation 7) (Page 37).
- promotion and support of health-related non-medical services (Recommendation 8) (Page 39).
- determination of research topics (Recommendation 24) (Page 61).
- innovation in the delivery of health and social services (Recommendation 25) (Page 67).

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[8] Throughout this report references to the State refer to the Executive, Legislative and Judicial branches of government (this also includes the recommendation of the stakeholders advising the State, implementing strategies and designing new solutions.)

[9] Ginsberg, P. "A World in Transition." *Business and Health*, April 1996, pp. 60-62.

[10] Solomon, J. "With or Without You." Newsweek, Aug. 15, 1994, pp. 58-59.

[11] Fuchs, V.R. *The Future of Health Policy*. Harvard University Press, Cambridge, MA, 1994.

[12] J.D. Wilkerson, K.J. Devers, and R.S. Given in *Competitive Managed Care: The Emerging Health Care System*. Jossey-Bass Publishers, San Francisco, CA: 1997, p. 359.

II. Strategies For State Action

Among most of the 1,000 citizens who participated in the different health planning forums, the proper response of the State was often discussed in terms of different and often competing roles and responsibilities with communities and the private market. Most citizens expressed the need for a balance between the State, communities and the market. Each had strengths and weaknesses. No one viewed any approach as always preferable to the others. If there was any common perspective across discussants it was that the State's role should be minimized and that as many functions as possible be assumed by communities and the private sector.

A majority of individuals suggested that the State should be responsible for two major goals:

- promoting the health status and well being of its citizens.
- assuring that needed health care goods and services be available to all New Hampshire residents regardless of their ability to pay.

The changes in the health care system required a review by the State of the policies and procedures that it will keep, those that it would eliminate and those it will change. The health planning work assisted this review. District Council members and other planning participants identified functions that they believed were or should have been within the jurisdiction of the State: [13]

- The design and application of health benefits.
- The financing of health benefits.
- Assuring the quality of care.
- Assuring the fiscal solvency of risk bearing entities.
- Mediation.
- Development of an information infrastructure.
- Monitoring and supporting communities.
- Monitoring and supporting markets.

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[13] See *The State, Communities and Individuals*: Roles and Responsibilities in New Hampshire's Health Care System, New Hampshire Department of Health and Human Services, Concord, NH, February 1997 for a detailed discussion of this topic.

The roles envisioned for the communities were not as extensive as those seen for the State. No one felt that any existing agency or organization could represent all of the health and social service interests at the local level. However, a number of individuals believed that entities were forming or could be formed that would allow communities to act as a partner with the State on all state-funded programs; to participate in market solutions; and control local markets for certain populations.

The functions that were identified as being within State jurisdiction are addressed in the four primary strategies outlined in this section:

- promoting access to health care coverage while managing costs;
- protecting and empowering consumers;
- re-defining public health; and
- partnering with communities.

There are a total of 27 recommendations for implementing these strategies. Each recommendation has a brief explanation, eg, monitor the number of uninsured in order to assess the impact of market and legislative actions. Some of the recommendations can be prioritized and achieved under existing administrative authority. Others will require legislative deliberation and action.

The following index of the recommendations is presented to guide the reader to areas of specific interest. An index is also included as Appendix C.

A. Promoting Access To Health Coverage While Managing Costs

Recommendation 1. The Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General, together with market participants, should jointly monitor and respond to market behavior. (Page 26)

Recommendation 2. Monitor the uninsured and underinsured to track the effectiveness of the changing market in addressing their needs. (Page 27)

Recommendation 3. Consider establishing a standardized set of benefit packages for the health insurance market. (Page 27)

Recommendation 4. Consider establishing a risk adjustment system for the health insurance market. (Page 28)

Recommendation 5. Establish a statewide health insurance purchasing alliance for small employers and for individuals. (Page 30)

Recommendation 6. Provide a subsidy for the purchase of private insurance coverage for those who are uninsured because they cannot afford it. (Page 34)

Recommendation 7. Determine the scope of "safety net" services that should be available, the necessary level and sources of funding to maintain these services, and who should provide the services. (Page 37)

Recommendation 8. Support and promote systems that coordinate health-related non-medical services with medical care to improve outcomes. (Page 39)

Recommendation 9. Revise the role of Certificate of Need to keep pace with the rapidly changing health care market. (Page 39)

Recommendation 10. Work with communities, market and provider representatives to establish both minimum standards of adequacy for the delivery system and a process and incentives for encouraging providers to practice within medical shortage areas or areas that do not meet minimum standards of adequacy. (Page 41)

B. Protecting And Empowering Consumers

Recommendation 11. Establish an independent mediator, with the authority to make recommendations, for disputes arising among consumers, providers, health insurers and managed care organizations. (Page 44)

Recommendation 12. Create an independent consumer hotline for complaints regarding health insurance coverage. (Page 45)

Recommendation 13. Promote and participate in an organization which would develop innovative quality monitoring and improvement activities. (Page 47)

Recommendation 14. Develop a coordinated monitoring policy for all health care services for which there is current State Legislative or regulatory authority. (Page 48)

Recommendation 15. Develop the capacity to provide data that allows citizens to review the health status of communities and the statewide population; to understand the performance of State and market functions; and to understand the status of community concerns. (Page 49)

Recommendation 16. Promote the private development of information that helps improve the health status of New Hampshire residents and the operation of the health care system. (Page 50)

Recommendation 17. Establish licensure for health care organizations that bear financial risk based on a formula that adjusts capital and reserve requirements to the number of covered lives served by an organization, its structure, and the percent of risk that the organization will assume. (Page 52)

Recommendation 18. Develop guidelines governing the transfer of financial risk from one entity to another. (Page 53)

Recommendation 19. Establish the capacity to track the number of self-insured plans, require such plans to disclose to their enrollees that they are self-insured, and provide support and guidance to individuals insured under such plans. (Page 54)

C. Re-Defining Public Health

Recommendation 20. Collaborate with the Turning Point Steering Committee to reassess the functions of public health. (Page 57)

Recommendation 21. Determine whether current baseline monitoring efforts are adequate or should be expanded to monitor health risks and outbreaks. (Page 58)

Recommendation 22. Implement improved coordination of health promotion and wellness activities across government agencies, managed care and other organizations. (page 59)

Recommendation 23. Determine the level of support which the State and private entities (such as managed care organizations) ought to provide to public and private health care provider training programs. (Page 60)

Recommendation 24. Determine the critical areas for public health and public research and establish criteria for public and private funding. (Page 61)

D. Partnering With Communities

Recommendation 25. Maintain and protect the Health Care Transition Fund to support innovations in the delivery of health and social services. (Page 67)

Recommendation 26. Retain the District Councils as a permanent part of health planning and policy development. (Page 70)

Recommendation 27. Develop operational standards for community benefits, with representatives from communities, non-profit providers, and representatives from the Department of Insurance and the Office of the Attorney General, that reflect community values. (Page 71)

II. Strategies for State Action:

A. Promoting Access To Health Care Coverage While Managing Costs

New Hampshire continues to enjoy the benefits of a strong economy and is among the nation's leading states in terms of the overall health of its residents. Despite this good news, New Hampshire's health insurance market still leaves an alarming number of people without health insurance coverage at considerable cost to the State's health care system in terms of uncompensated care and health insurance premiums. According to a December 1997 study commissioned by the New Hampshire Insurance Department, 10.9% of New Hampshire's 1.2 million residents were without health insurance in 1996—approximately 130,000 persons.

A Coordinated, Multifaceted Reform Strategy

The challenge in addressing the problem of the uninsured through a voluntary approach is to coordinate the effort with other health reforms so as to avoid expending resources on initiatives that fail to eliminate the root of the problem or that merely shift the problem from one area to another. The strategies and initiatives outlined here are designed to improve access to health insurance coverage and control costs through incremental reforms that address all aspects of the health insurance market and that are coordinated to achieve maximum combined effect.

The core strategy is three-fold:

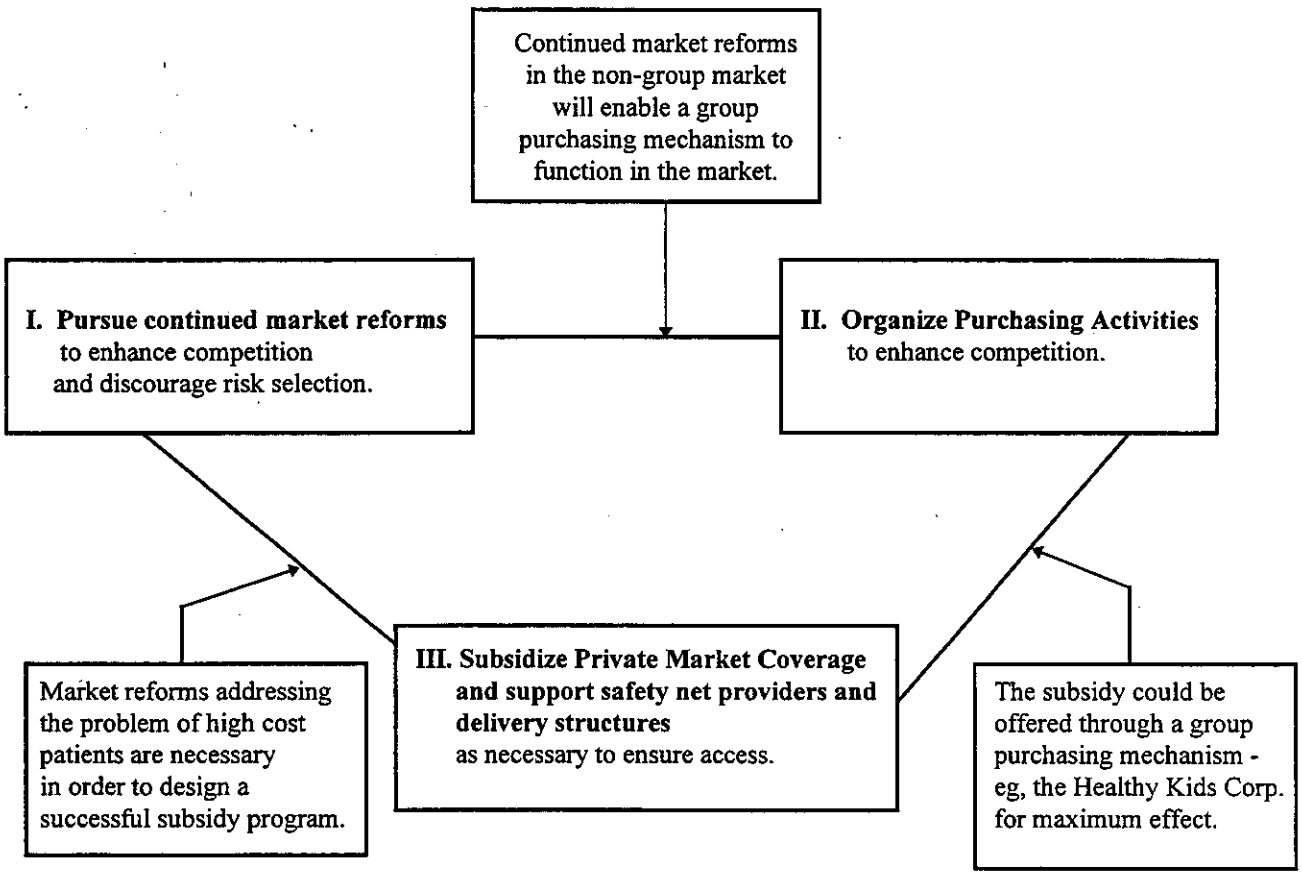
1. pursue continued insurance market reforms to enhance competition and discourage risk selection;

2. organize purchasing activities to enhance competition; and

3. subsidize private market coverage and support safety net providers and delivery structures.

Figure 2 provides a pictorial depiction of this approach. A number of synergistic effects are achievable through a coordinated approach. For example, in order to maximize the effect of providing a subsidy for insurance coverage, it might be advisable to provide the subsidy through a group purchasing mechanism (such as a purchasing alliance or existing employer coverage). Similarly, any comprehensive program to provide a subsidy for insurance coverage must be accompanied by a regulatory effort to address the problem of financing coverage for high cost patients. If insurance carriers are allowed to shift high cost patients to the subsidy program, the program could become financially insupportable.

Figure 2
Promoting Access to Health Coverage While Managing Costs



Most participants in the health planning work felt that the State should adopt as a priority the goal of universal health care coverage for New Hampshire's citizens. As used in this context, "universal coverage" means that 100% of the residents of the State have coverage. Most planning participants also felt that coverage expansion should be based on voluntary participation by individuals and employers. It is important to note that voluntary participation and universal coverage are not completely compatible goals. This is because voluntary participation means that there can always be a group of individuals and employers who can afford to purchase health coverage but do not. If that is the case, universal coverage can be a goal but it may not be

achieved in a voluntary system. No country that has achieved universal coverage has been able to do it without mandatory participation (no one can choose not to be covered), mandatory financial contributions, and government controls over total expenditures.

What is more achievable in a voluntary system is what we might call "universal coverage availability." Universal coverage availability exists when all persons wishing to have coverage do in fact have it. The following recommendations developed from the health planning work are designed to promote universal coverage by way of universal coverage availability. This approach recognizes that expansion of coverage must be incremental and is dependent upon the funds that are available as well as the existence of sufficient political and popular support.

1. Pursue continued insurance market reforms to enhance competition and discourage risk selection.

Many advocates for health care reform have proposed that only competition and private markets will be capable of controlling costs, ensuring access, and maintaining quality of care. However, a market solution is viable only when there is a sufficient level of market competition. The market benefits derived from pure competition (minimum costs, maximum efficiency, high quality of care) do not necessarily accrue in the current health care environment. For markets to maximize benefits, there must be a large number of buyers and sellers, a uniform product, minimum barriers to entering the market, and complete information availability on the cost and quality of the services being sold. These conditions are not present in the health care market. The barriers to competition in the health care market which must be addressed if a market-based approach is to succeed are as follows:

- Consumers and purchasers have inadequate information about the cost, quality and effectiveness of the services being purchased.
- Consumer choice is limited.
- Consumers of services are often not the buyers of services.
- Health benefit plans are not readily comparable to another.
- There are incentives in the health insurance market that are unrelated to efficiency or value, most importantly, the strong incentive to minimize costs by avoiding high cost individuals.
- Due to market consolidation, some health insurers and providers approach monopoly[14] or oligopoly [15]power.

The State cannot and should not attempt to create perfect competition in health care. The public policy goal is to determine when the imperfections are acceptable and serving the best interests of the citizens of New Hampshire, and when they are not. The market should be subject to

[14] Monopoly refers to the market condition that exists when there is only one seller with exclusive control of a service that makes it possible to manipulate prices.
[15] Oligopoly refers to the market condition in which prices and other factors are controlled by a few sellers.

empirical tests. If it works, the State should refrain from being involved. When the system is not working, the State should intervene or assist the market. It is important to note here that the market's needs and interventions may be different by region of the state. For example, the characteristics of the market are different North and South of Concord.

Market participants are key to developing those standards by which market performance would be assessed. This section explores interventions that are likely to promote this latter goal.

Interagency Coordination of Market-Related Functions

Recommendation 1. The Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General, together with market participants, should jointly monitor and respond to market behavior.

When economists discuss the market in health care they either dismiss its application because the health care system fails to meet the definition of a pure market or they dismiss the imperfections as unimportant compared to the power and effectiveness of market forces. In either case economists have failed to operationally define, in economic terms, when the imperfect health care market is working well and when it is not. If markets are to be used to solve problems that have broad social and political implications, then there must be operational standards that indicate when the State and communities should intervene in the public interest and when they should refrain from disturbing market behavior.

In order to support the proper development of market reform, the various state agencies involved in the regulation of market behavior should jointly set standards for the proper functioning of the health care market. There are three State agencies whose mission directly concerns the status of the health care market: the Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General. A coordinated approach to improving competition in the health care market and protecting the public interest requires the concerted effort of these agencies.

This coordination can be achieved through the vehicle of an inter-agency agreement. This agreement should address the following functions:

- development of standards for when the market is performing well and guidance for when the market is performing poorly and requires State intervention;

- assessment of current market conditions by comparing the performance of different sellers (the insurance companies, health plans and providers), buyers (self-insured individuals, private employers and government), and consumers;

- collection, analysis and distribution of information that will aid in monitoring market behavior and in making decisions regarding market interventions; and

- establishment of a cooperative framework for monitoring and prosecuting anti-trust violations, enforcing community benefit obligations, promoting competition, subsidizing the

purchase of coverage to ensure affordability for all, regulating managed care, and for licensing risk-bearing health care organizations.

A Public Health Perspective

Recommendation 2. Monitor the uninsured and underinsured to track the effectiveness of the changing market in addressing their needs.

Markets are designed to serve those who have money and income as efficiently and effectively as possible. Markets work within the existing distribution of wealth. If you cannot afford a good or service, markets will be unresponsive to your needs. That is the nature of markets. From the perspective of promoting the health goals, it is important to examine the impact of markets on the entire population including those who cannot afford to make purchases in the health care market.

In order to track the effects of the changing market on the health status of the population, the State should also track the effect, if any, those changes impose on those who cannot participate in the market. Resources should be committed to improve the capacity of the State to collect and accurately analyze this data. New Hampshire should sponsor an annual survey on the health care coverage of its citizens. The most recent Survey was conducted in 1989.

The ability of the state to accurately define, assess, and analyze the scope of the problem of the uninsured in New Hampshire has a direct bearing on the development and success of public and public-private partnerships to expand coverage to the uninsured and improve the health status of the people of New Hampshire.

Standardized Benefits

Recommendation 3. Consider establishing a standardized set of benefit packages for the health insurance market.

There are three interrelated structural problems in the insurance market relative to health benefit design, namely:

- **The difficulty buyers have in doing comparison shopping**. This is a particular problem for purchasing coverage in the individual and small group insurance market. Small purchasers must choose among different policies and plans that have different and often obscure benefits and coverage limitations.

- **The seller's ability to fragment the market and avoid expensive patients through benefit design**. If vendors exclude particular kinds of specialized care or coverage for certain prescriptions, they also reduce the likelihood that people needing that care or that drug will purchase that health plan. On the other hand by offering services that a healthy patient would find attractive - eg, membership in a health club - the plan can attract a disproportionate number of individuals with a low risk of being ill.

- **The problems encountered in trying to evaluate the quality between different benefit packages and health plans.** When benefit packages vary across all plans, the differences in health outcomes or other quality measures may be attributable to differences in benefit coverage and not necessarily the quality of care.

One approach to these problems is to encourage health insurers to offer a standardized set of benefit packages. All covered persons would be able to choose among a number of different benefit packages designed by the State in consultation with insurers. Consideration should be given to whether these will be the only benefit packages that can be offered by insurance companies and health plans. Establishing a set of standard benefit packages can be effective in addressing problems of comparison shopping, fragmentation of the market and quality while preserving choice of benefits.

Risk Adjustment

Recommendation 4. Consider establishing a risk adjustment system for the health insurance market.[16]

Under fee-for-service, a high cost patient with indemnity insurance was a source of revenue. Every time a service was rendered, the provider was paid. In the emerging health care system, those incentives are reversed. HMOs and other risk bearing entities are now often paid on a capitated basis - they receive a fixed price per enrollee per month for all of the services that person may need. Sometimes it is not only the health plan that is capitated. Many of these plans also pay hospitals, physicians and other providers on a capitated basis.

Capitation places a premium on healthy patients (the providers receive their fixed price for each of these enrollees but incur little or no costs caring for these individuals) and creates an aversion to sick patients (whose costs greatly exceed the revenue they generate). If the population is ranked by use of service, the top 1% of the population account for 30% of the health care expenditures, the bottom 50% of the population for 3% of the expenditures. In the individual market in New Hampshire, the situation is even more acute. The most expensive 1.5% account for 54% of all health expenditures in that market.[17] It is far easier for an HMO to make money by avoiding expensive patients - a process referred to as *risk selection* - than it is to be efficient or effective.

Some of this risk selection is the result of consumer choice - healthy patients that make little use of the health care system will choose a less expensive plan. Some of this biased selection is the result of how managed care organizations structure their benefits (restricted access to specialists may discourage sick patients from enrolling); market their services (managed care organizations

[16] As a short term measure to address the crisis in access to insurance coverage in the individual market, the New Hampshire Insurance Department is implementing a risk adjustment and risk subsidy mechanism for that market only. All health insurance carriers in all markets will be assessed an amount that is based on their number of covered lives. The fund generated in this manner will be used to offset expenses for high cost patients among carriers that currently offer insurance policies in the individual market.

[17] State of New Hampshire, Insurance Department, *An Analysis of the Non-group Market with Recommendations for Change*. October 27, 1997.

frequently promote membership in health clubs in marketing campaigns - a service clearly more attractive to healthier patients); or enroll and disenroll patients.

Risk selection has long been recognized as an imperfection in the health insurance market. When a delivery system consists of a mix of capitated managed care plans and fee-for-service plans, risk selection can actually increase the total amount of money spent on health care. This occurs because managed care organizations often price the cost of their coverage at rates that are slightly less than fee-for-service insurance coverage. If managed care organizations can attract a healthier population than fee-for-service, then a greater percentage of those remaining in the fee-for-service system will be infirm, and the fee-for-service rates will increase. The result: "... a small amount of biased selection, well within the range of current research evidence, is enough to increase total costs."[18]

This problem persists even when the delivery system consists of only managed care organizations. Risk selection means that some plans - those that are more proficient at enrolling and keeping healthy patients and avoiding or getting rid of unhealthy patients - will reap considerable profits that are unrelated to their performance. Other plans that conscientiously deliver efficient and effective care to very sick patients will lose money.

Risk selection and risk segmentation in the market are phenomena that threaten to dwarf all private and public efforts to craft incentives that promote efficiency and equity in the health care market. While moving to standardized benefits packages allows the consumer to make apples-to-apples comparisons of plans and discourages risk selection based on benefit design, it does not get to the heart of a health plan's capacity to risk select. Failure to adequately address risk selection will continue to have serious consequences both for access to care among vulnerable populations, and for the financial viability of health plans.[19] In order for competition to work, health plans must compete only on efficiency (a comparison of output - a medical service - with the cost it took to produce) and quality and not on their ability to selectively enroll healthy patients or disenroll the sick.

The federal government and managed care advocates have proposed that the solution to risk selection is a system of payment adjustments to health plans known as *risk adjustment.*[20] There are two types of risk adjustment: *prospective* and *retrospective*. Under retrospective risk adjustment, all of the health plans in a market are required to pay a portion of their premium income into a pool which is used to reimburse the plans in a manner that is proportional to the number of high cost patients for which they are responsible. In prospective risk adjustment, at the beginning of each year - before their enrollees use any services - an individual's capitation payment to the HMO would be increased or decreased based on their characteristics (eg, age, sex, residence, etc.) that contribute to their probability of being sick.

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[18] Randall Elliss and Thomas McGuire, "Setting Capitation Payments in Markets for Health Services," *Health Care Financing Review,* Vol. 8, No. 4. Summer 1987, p. 61.

[19] Annie Gauthier, Jo Ann Lamphere and Nancy Barrand, "Risk Selection in the Health Care Market: A Workshop Overview," *Inquiry*, Vol. 32, No. 2., Spring 1995, p. 15. Nancy Barrand is a senior program officer in the Robert Wood Johnson Foundation.

[20] The Health Care Financing Administration is in the process of collecting data on Medicare managed care enrollees with the expressed purpose of developing prospective payment rates to health plans. The Balanced Budget Act of 1997 requires that the payment system be in place in the year 2000.

There are several approaches the State could take:

- as empirically sound prospective adjustments become available those adjustments could be incorporated into the capitation payments for State employees and Medicaid recipients;
- mandate coverage for high cost cases for all State residents;
- set up a fund that is dedicated to high cost patients so that retrospective adjustments could be made to health plans;
- monitor enrollment and disenrollment of high cost patients among the health plans and;
- monitor health plans to assure that patients receive the medically recommended protocol for the specific conditions involved.

2. Organize Purchasing Activities to Enhance Competition.

Recommendation 5. Establish a statewide health insurance purchasing alliance for small employers and for individuals.

A health insurance purchasing alliance is a private organization that secures health insurance coverage for the workers of member employers who have chosen to participate. The primary goal of a such an alliance is to obtain better value (cost and quality) in purchasing health insurance by consolidating responsibilities and resources. A purchasing alliance can also foster competition (by reducing risk selection and assisting employees to choose a health plan) and reduce the overall level of the uninsured (by making insurance more affordable).

Functions that a purchasing alliance performs are:

- negotiating and contracting;
- marketing and enrollment;
- premium collection and distribution;
- data analysis and evaluation; and
- plan performance measurement.

A health insurance purchasing alliance builds on market reforms and operates best with the kind of insurance reforms that are working in New Hampshire.

The planning work revealed a great deal of interest in the concept of a statewide purchasing alliance for the small group market and perhaps (separately) for the individual market. It is

believed that this could address some of the problems small employers and individuals face in purchasing coverage. The consolidation of health plans and provider groups gives small buyers even less power than they had before. Since 94% of the employers in New Hampshire have fewer than 100 employees and 70% of New Hampshire's employees are in firms with fewer than 100 employees, the small employer's ability to select a health plan at the best possible price might need to be augmented. The experience in California, Florida and other states that have state sponsored purchasing cooperatives for small businesses is encouraging.[21] Through group purchasing, small businesses and individuals have access to a wider range of choices at less cost. The experience from other States indicates the need to keep the cooperative open to bids from all health plans and to encourage independent insurance agents or brokers to sell the cooperative's products.

Some purchasers will prefer to form a coalition for reasons other than purchasing health insurance as one group. The New Hampshire Health Care Purchasers Roundtable is an example of such a coalition. Larger purchasers of health coverage in New Hampshire, both public and private (including the Department of Health and Human Services), have come together to form the Roundtable.

(See also APPENDIX B for further discussion of the Health Care Purchasers Roundtable).

3. Subsidize Private Market Coverage and Support Safety Net Providers and Delivery Structures.

There are two significant factors that contribute to the lack of health insurance coverage. The first is a lack of access to insurance through an employer. Slightly over half (51.2%) of all uninsured persons in the United States work full time, and 59% of all uninsured children live in families with a full time wage earner. The second is a lack of affordable coverage. Even though a majority of the uninsured work full time, the lack of affordable health insurance options plays a large part in the inability of the uninsured to obtain health care coverage. Health insurance premiums in the individual market are simply unaffordable for many low wage workers. While more employers offered health insurance during the late 1980s though mid-1990s, more employees declined coverage due to the shift of the cost of increased premiums and out-of-pocket costs to working families.[22] Research indicates that families do not have enough disposable income to purchase health insurance until family income reaches 250% of the federal poverty level, or $41,125 for a family of four.[23]

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[21] Presentations by Sandra Shewry, Deputy Director of California's Benefits and Plan Relations, and Rick Lutz, Director of the Florida Division of State Health Purchasing, "Purchasing Cooperatives: Expanding Access Through Market Based Initiatives." Coming of Age in State Health Reform, National Academy for State Health Policy, Portland, ME, August 11, 1997.

[22] The Lewin Group, *Paying More and Losing Ground: How Employer Cost-Shifting is Eroding Health Coverage for Working Families*, AFL-CIO, Washington, DC, February 19, 1998. See also P. Cooper and B Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987-1996", *Health Affairs*, (16) 6, pp. 142-149, 1997.

[23] D. Chollet, *"Who are the Uninsured"* at the AHCPR *What Do We Do About the Uninsured?: Options for States*, Charlottesville, VA, September 15-17, 1997.

New Hampshire exceeded the national average of employers who offered health insurance - ranking 9th among the 50 states and the District of Columbia (all 6 New England states ranked in the top 15).[24] [25] Nationally, the firms most likely to offer health insurance coverage are the larger, older, unionized businesses, with fewer low-wage and part-time workers. Businesses in retail, construction and agriculture/forestry/fishing are the least likely to offer health insurance to their employees. Table 3 shows how New Hampshire businesses compared to the United States.

Table 3

Private Establishments, Percent Offering Health Insurance, and Percent with Other Characteristics [26]

	US	NH	NE Avg	NE Range
Number of Establishments	6,276,800	33,300	58,000	20,400 - 149,800
Percent offering health insurance	51.6	57.5	59.1	55% - 64.5%
Rank	---	9	---	3 - 14
Percent with 50% or more employees that are low-wage	16	12	11.9	9.9 - 14
Percent unincorporated	33.2	37.7	31	20.9 - 37.7
Percent in business less than 5 years	12.4	13.6	12.2	10.4 - 14.8
Percent in retail	23.2	30.4	24.2	19 - 30.4
Percent with 75% or more employees that are full-time	60.3	56.1	54.7	52.6 - 57.9
Percent in manufacturing	8.1	8.3	9.2	6.9 - 11.8
Percent in multi-State firm	13.8	13.3	11.8	10 - 13.3
Percent with union employees	3.2	0.9	2.2	0.9 - 4.2*
Percent in metropolitan area	78.7	69.1	76.3	29.9 - 100

*Includes two states (ME (1.5%)and VT (1.3%)) whose figures did not meet the standard for reliability or precision.

[24] Centers for Disease Control/National Center for Health Statistics, "Employer-Sponsored Health Insurance: State and National Statistics," Hyattsville, MD., 1997.

[25] This study was done in 1993. At this point in time, there is no more current information on New Hampshire employers. This is a potential topic for a statewide survey.

[26] Ibid. Adapted from Table 5, p.23.

While the news was good regarding the percentage of businesses that were offering health insurance in New Hampshire (at the time of the study), it was tempered by the fact that New Hampshire also had higher percentages of businesses that are less likely to offer coverage - newer, non-unionized and retail firms. In addition, there are fewer firms in the State that have more than 75% full-time workers (New Hampshire firms are also primarily small businesses).

The discussion below on **Subsidizing Private Market Coverage** can be referred to as a "population-based" solution - the responsibility would be placed on the individual to choose health insurance coverage (another alternative would be to subsidize an individual's coverage through his or her employer - or an "employer-based" solution).

Subsidizing Private Market Coverage

The District Councils supported the incremental implementation of voluntary health insurance coverage. In order to expand the opportunities for New Hampshire's uninsured to purchase health insurance coverage, the State must determine:

- the scope of the health care benefit package and its probable cost;
- who will be eligible for the benefits package;
- the best estimate of numbers of uninsured children and adults in the state;
- the amount of revenue needed to support the expansion of insurance coverage; and
- the process of establishing and administering the expansion.

Principles of Expansion. District Councils discussions have yielded a consensus on a number of key aspects of financing coverage. In short, the debate about how to best further the goal of achieving universal coverage for health insurance revolved around the appropriate role of government in regulation of the health care market. A large majority of participants agreed that the following principles should be part of any expansion of coverage.

- Health care coverage, especially preventive care, for the uninsured is a State concern.
- All individuals should pay something towards the cost of their care, no matter how small an amount.
- Individuals should contribute to the control of costs, ie, engage in preventive behaviors such as not smoking and exercising on a regular basis.
- The State is responsible for establishing the benefit package that will be available to the uninsured.

- The cost of coverage should be subsidized for individuals who could otherwise not afford it.

- The expansion of coverage should not encourage employers to drop private coverage for some employees in favor of public coverage (the "crowd out" phenomenon).

Recommendation 6. Provide a subsidy for the purchase of private insurance coverage for those who are uninsured because they cannot afford it.

The expansion of coverage to the uninsured would be accomplished incrementally. Step I would expand opportunities to purchase health insurance coverage for a large portion of the uninsured children in New Hampshire. Children living in families that earn between 185% and 300% of the poverty level would benefit from this program. Coverage would be available on a subsidized basis dependent upon the family's income level.

Step II would expand opportunities for uninsured adults to purchase health care coverage. Families earning between 100% and 300% of the federal poverty level would qualify for this program. As with the children's expansion, adult coverage would be available on a subsidized basis dependent upon family income.

All options for expansion of coverage to the uninsured require cost sharing between the federal government, the State, and individuals. Individuals would contribute to the cost of expansion through premium payments and co-pays, some portion of which would be subsidized dependent upon family income. The federal funds would flow from three sources: the current Medicaid Program, the Children's Health Insurance Program (CHIP) established under the 1997 Balanced Budget Agreement, and dollars available through a Medicaid Managed Care Waiver proposal.

Step I. Expansion of health insurance coverage to uninsured children.

Medicaid Outreach. It is estimated that 40-50% of New Hampshire children eligible for Medicaid are not enrolled in the program in New Hampshire. Of the estimated 18,000 uninsured children, approximately 8,000 of these children are presently eligible for Medicaid. The 1997 Balanced Budget Act which established the CHIP requires states to enroll all eligible children into Medicaid and provides federal funds for outreach.

In New Hampshire, children in families below 185% of the federal poverty level qualify for Medicaid. Enrolling as many eligible children as possible into the Medicaid program would reduce the number of the uninsured. The federal government would finance one half the cost of enrolling the estimated 8,000 eligible children into the Medicaid program, with the state paying the other half as a result of this expansion falling under the extension of the current Medicaid program.

Child Health Insurance Program (CHIP). The most likely vehicle for the initial expansion of coverage to children is the Children's Health Insurance Program (CHIP), authorized under Title XXI, the 1997 Federal Balanced Budget Act. Under this program, the federal government will contribute 65% of the cost of the expansion with the state contributing the remaining 35%.

Under the CHIP eligibility formula, New Hampshire children in families between 185% and 300% of the federal poverty level would qualify for the program. The CHIP plan is designed to be implemented in two phases. The first phase is a Medicaid Expansion for infants ages one to one whose family income is greater than 185% FPL and equal or less than 300% FPL. Phase 1 was implemented on May 1, 1998. The second phase, scheduled for implementation in January 1999, is the purchase of health insurance via the New Hampshire Healthy Kids Corporation for children ages 1-19 whose family income also falls between 185% to 300% FPL.

Step II. Expansion of insurance coverage to uninsured adults.

Step II of the initiative would expand opportunities for uninsured adults to purchase health insurance coverage up to 300% of the federal poverty level. It is estimated that there are approximately 100,000 uninsured adults in New Hampshire. The expansion of health insurance coverage to adults is substantially more expensive than expanding coverage to children - adults are more intensive users of the health care system - and their health care claims experience is reflected in higher premium rates. As with the expansion of coverage to children, the expansion of coverage to adults would be accomplished by a combination of federal, State, employer and individual premium dollars.

Obtaining the Resources to Expand Coverage to the Uninsured

As briefly discussed above, expanding coverage to the uninsured depends upon a partnership between the federal government, State government, and New Hampshire's citizens. Obtaining the dollars necessary to expand coverage would require the re-direction of current health care expenditures, the raising of new revenues, or both.

A number of other states have implemented initiatives to cover both uninsured children and adults. In order to finance expansions of coverage, states have pursued a variety of strategies, most of which fall into these broad categories:

- Limited pools of money that are non-renewable;
- Re-allocation of current spending;
- Dedicated revenues; and
- Employer dollars leveraged through purchasing alliances.

Limited pools of money that are non-renewable, such as:

- Medicaid Enhancement Funds that New Hampshire Hospitals utilize for services to Medicaid enrollees and other low income patients;
- dollars from the federal Tobacco Settlement currently under negotiation between the White House and Congress; and

ensure that non-profit assets being used to provide health care services and benefits remain in the available community for that use).

Re-allocation of current spending through:

- individual accountability to improve health status and reduce costs through lifestyle choices;
- application of research that indicates a wide variation in costs for the same medical procedure in different geographic areas (establishment of medical protocols holds some promise for redirecting resources - outcomes research and best practices models are examples of this approach);
- rigorous analysis of current health care spending within New Hampshire to determine where health care dollars are currently being spent and where reallocation is possible; and
- redesign of categorical grant programs in order to decrease duplicative administrative functions (which may require application for federal waivers).

Dedicated revenues, such as:

- cigarette tax increases dedicated to the subsidization of expansion costs ($1.8 million is raised for every penny increase in the cigarette tax - Vermont and Massachusetts financed their health care expansions this way; CHIP is financed through the federal tax on tobacco) and;
- provider taxes or health plan assessments (revenue raised from these sources would comprise a pool of dollars that could support coverage expansion).

A Note on District Council Reaction to Financing Options

During the month of January 1998, the Office of Planning and Research staff held meetings with the District Councils to identify their preferences for financing options to support the expansion of health insurance coverage to both uninsured children and adults. The information presented above (in Subsidizing Private Market Coverage) was discussed with District Council members.

There was significant agreement among District Council members on the strategy to cover uninsured children first, which was seen as a meaningful foothold to initiate a program that could be expanded to adults. Most felt that the State would need to obtain the funds from several sources concurrently (eg, non-renewable revenue sources like the Tobacco Settlement combined with dedicated revenues such as the cigarette tax). There was also support for an assessment on health care carriers and the concept of purchasing cooperatives. Some saw the purchasing cooperatives as a means of forcing efficiencies in the health care market that might allow for re-direction of dollars.

cooperatives as a means of forcing efficiencies in the health care market that might allow for re-direction of dollars.

Participants urged the State to use caution in redesigning any categorical grant programs - block grants to communities could result in certain groups being excluded from services. The adoption of any "block granting" process should be a financing mechanism that permits community organizations to pursue a set of goals and objectives held in common with the State.

Participants supported the concept of developing ways to capture savings from the current health care system and re-direct them elsewhere, however, identifying the mechanisms to accomplish this goal proved elusive. While members still thought savings could be realized when individuals adopted healthier lifestyles, they recognized that this was a long term proposition.

What follows in the section on **Safety Net Providers and Delivery Structures** can be described as a "provider-based" solution. Community health centers, hospitals, clinics and other providers that disproportionately care for the uninsured and the underinsured might require direct financial subsidies. If every resident within the State had health care coverage, direct subsidies would not be necessary. Until that happens, however, serious consideration must continue to be given to supporting these providers. The provision of health-related non-medical services as well as the adequacy of the delivery system and structures also improve access to care.

Safety Net Providers and Delivery Structures

The recommendations in this section take into account the fact that voluntary and incremental expansions of health insurance coverage will always leave a certain number of uninsured. They also take into account the fact that universal coverage, even if it is realized, may not guarantee that everyone will have access to all needed health care services. This is especially true for persons with special needs such as the need for transportation assistance or other health-related non-medical services.

Recommendation 7. Determine the scope of "safety net" services that should be available, the necessary level and sources of funding to maintain these services, and who should provide the services.

The "safety net" consists of those institutions, programs and providers devoting substantial resources to serving the uninsured and vulnerable populations. Although any provider can participate in the safety net, community health centers, hospitals, clinics and categorical providers (family planning, child health and prenatal services) are generally considered to form the core safety net institutions. [27] Perhaps the most persistent problem facing the State is what will become of the publicly-funded "safety net" programs. Privately-funded efforts that extend services to the uninsured, such as the Seacoast HealthNet, HealthLink (in the Lakes Region), and the Greater Derry Community Health Services face similar concerns.

[27] Raymond Baxter and Robert Mechanic, "The Status of Local Health Care Safety Nets", *Health Affairs*, vol. 16, no. 4, July-August 1997, p. 9.

The number of uninsured individuals in New Hampshire could be decreased by some of the present initiatives the State is undertaking which are discussed above. However, a substantial number of people will remain uninsured during the transition stages of incremental reforms (moving towards universal coverage) or due to voluntary participation.

Both Minnesota and Oregon offer insights to New Hampshire as to what can be achieved through incremental and voluntary reforms. In the case of Minnesota, recent analysis has shown that MinnesotaCare has been successful in keeping the number of uninsured low and stable at six percent [28] (while the number of uninsured children dropped by 40%, the number of uninsured single adults had increased from 29% to 36%).. As for Oregon, the Oregon Health Plan has made significant strides in decreasing the number of uninsured, but officials estimate that they expect five to eight percent of Oregonians will remain uninsured.[29] This factor and Oregon's experience to date, has generated a great deal of concern around the status of Oregon's safety net providers (particularly community and migrant health centers). As a result, the state decided to conduct a study as to whether these providers are suffering adverse risk selection and to award a series of grants to collaborative community partnerships of safety net providers (hospitals, businesses and consumers) "to preserve needed safety net capacity."

Participants in the health care planning work have supported the view that the State should continue to provide the needed care for uninsured and vulnerable populations by maintaining a provider safety net of health and social services. There was strong local support for assuring that "safety net" services and "essential local providers" were protected. However, there was no consensus as to the necessary extent of the "safety net" system, where resources should come from, the extent to which these services should be provided through health care coverage, or how these services should be integrated at the community level.

Participants in the planning process voiced a concern that the total resources committed to charitable care and other forms of non-reimbursed care were disappearing. The pressure in the evolving health care system is not only to squeeze out the inefficiencies but to eliminate cross subsidies.[30] If cross subsidies among patients are eliminated, over time, providers without endowments and independent sources of income will be unable to provide care to the uninsured.

Safety net providers tend to rely on Medicaid for a large portion of their revenues. The movement of the Medicaid population into managed care and changes in federal law could result in decreased revenues and a decreased capacity to care for the uninsured and vulnerable populations. While reports from around the country indicate that access to primary care services

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[28] K. McCall, "Who Is Still Uninsured in Minnesota?", JAMA, (248)14, pp. 1191-1195, October 8, 1997. This analysis also found that the main barrier to insurance was cost and that the program had not caused employers to drop coverage. Minnesota received a Medicaid Section 1115 waiver in 1992 for this program.

[29] Correspondence from Robert DiPrete, Director, Oregon Health Council, to Christine Shannon, New Hampshire Department of Health and Human Services, Office of Planning & Research, February 13, 1998. Oregon received one of the earliest Medicaid Section 1115 Waivers.

[30] "Cross subsidies" are those instances in which one patient, eg, a privately insured patient, is charged more than their costs in order to pay for another patient that was uninsured.

for Medicaid Managed Care enrollees have increased,[31] the ongoing changes in Medicaid and the market (eg, increased competition among providers, decreased capitation rates, and the transfer of more risk to contracted providers) suggest greater challenges in the future to safety net provider's ability to sustain their current levels of services to the uninsured.[32]

The changing health care environment will require ongoing monitoring of resources and the needs of the uninsured and vulnerable populations. The changes in Medicaid and the market need to be tracked at the State and national levels. Safety net providers should be monitored for "early warning signals" (patient volume, services and financial status) and the uninsured surveyed to find out if they have trouble getting appointments for care.[33]

Recommendation 8. Support and promote systems that coordinate health-related non-medical services with medical care to improve outcomes.

Participants in the planning process spoke of what they wanted for themselves and their family members. Many focused on the importance of health-related non-medical services (such things as counseling, nutritional services, social work, personal attendants, homemaker care, transportation, etc.). Some argued that they were more important than medical care. Individuals pass through different stages as they try to achieve their highest level of function and independence. Each stage requires a different mix of medical and health-related non-medical services.

The Health Care Transition Fund Community Grant Program projects provide examples of how communities are working on the structural changes in the delivery systems that coordinate both medical and health-related non-medical services. A prime example of this is the development of integrated service networks that are being designed to meet community needs. Proposed pilot projects in the draft long term care plan for Medicaid recipients *Shaping Tomorrow's Choices*[34] also illustrate the recognition that both types of services are important to an individual's health status. Where possible, the Department will also pursue opportunities to combine categorical funding in support of integrated service delivery.

Ensuring a Minimally Adequate Delivery System

Certificate of Need

Recommendation 9. Revise the role of Certificate of Need to keep pace with the rapidly changing health care market.

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[31] Suzanne Felt-Lisk, Mary Harrington, and Anna Aizer, "Medicaid Managed Care: Does It Increase Primary Care Services in Underserved Areas?", Mathematica Policy Research, Inc., for the Health Resources and Services Administration, Bureau of Primary Health Care, November, 1997.

[32] One set of New Hampshire safety net providers - community health centers - reported a significant increase in the numbers of uninsured seeking their services during 1997. A study is being conducted to confirm those numbers and describe who these people are and why they are uninsured.

[33] Op Cit. "Medicaid Managed Care: Does It Increase Primary Care Services In Underserved Areas?"

[34] NH Department of Health & Human Services. *Shaping Tomorrow's Choices: A Report to the New Hampshire General Court on Long Term Care* DRAFT, Concord, NH, January 21, 1998.

"A Certificate of Need (CON) is issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development."[35]

The State controls the supply of hospitals, nursing homes and other institutional settings through the Certificate of Need process. Before providers can construct new facilities, before renovations in excess of $1.5 million in acute care hospital or $1 million in nursing homes or specialty hospitals can begin or before equipment that costs in excess of $400,000 can be purchased, providers must receive approval from the State.

CON traces its formal origins to federal legislation - the 1974 National Health Planning and Resource Development Act. Academics and government policy analysts assumed that supply drove utilization and costs - that a built hospital bed was a filled bed. Certificate of Need was born in a time when fee-for-service and cost-based reimbursement were the dominant forms of reimbursement and providers were unaligned and independent agents. Hospitals and nursing homes were able to shift the risk of their investments in construction and equipment onto consumers because they were paid on the basis of cost (an incurred cost was a reimbursed cost). Rather than change the reimbursement systems, government chose to impose controls over the supply. In practice, the process was generally ineffective.[36]

When Congress failed to reauthorize the CON legislation in 1987, many states continued to fund the CON agency on their own. Although 35 states currently have CON programs, they are coming under closer scrutiny.

The evolving health system, on the other hand, encourages price competition, increasingly relies on capitation and fixed prices to pay providers and tends to discourage the unnecessary use of services. If private investors build unnecessary facilities or buy technology that is underutilized, the investors will lose money. In this environment, the importance of Certificate of Need is diminished. The State should consider alternatives or modifications to a regulatory mechanism that is premised on reimbursement mechanisms and provider structures that are in the process of being phased out.

In the new health care system one compelling reason for maintaining CON would be to protect medical shortage areas. As noted below in the discussion of the minimum delivery system, some areas within the State have an inadequate supply of providers and may require government support. Certificate of Need could be used to insure the integrity of these fragile delivery systems. Instead of acting as a barrier to entry - CON would be used as a barrier to exit for these

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[35] Alpha Center. *Glossary of Terms Commonly Used in Health Care*, Washington, DC, 1996.

[36] During the 1970s and early 1980s research on Certificate of Need programs offered a general indictment of Certificate of Need. For example, Salkever and Bice found that CON slowed the rate of change in the bed supply, increased assets per bed, did not change total hospital assets and had no effect on hospital costs. D. Salkever and T. Bice, "Certificate of Need and Hospital Costs," in M. Zubkoff, I. Raskin and R. Hanft (eds.), *Hospital Cost Containment: Selected Notes for Future Policy*, New York, PRODIST, 1978. See also, F. Sloan and B. Steinwald, *Insurance, Regulation and Hospital Costs*, Lexington Books, Lexington, MA, 1980; and, F. Hellinger, "The Effects of Certificate of Need Legislation on Hospital Investment," *Inquiry*, June, 1976.

areas. A Certificate of Minimum Need could be created that would give preferential treatment to institutions, equipment, or providers in medical shortage areas.[37]

Another reason for maintaining a CON function in the new health care market is the issue of "niche markets". The market allows entrepreneurs to provide services in profitable niche markets: outpatient surgery, cardiac care centers, cancer centers and rehabilitation facilities. By siphoning off the business for the profitable services, these niche providers reduce the capacity of community hospitals to subsidize the uninsured or provide needed but non-profitable community services. Some have argued that niche providers are successful because that are more effective and less expensive than their competition; that the health care system needs more of them, not less.[38] If niche providers fail to provide community benefits, they could be taxed or required to provide community benefits. Those revenues could then be used to pay for the care of the uninsured and other community benefits.

Appropriate Standards for a Minimum Delivery System

Recommendation 10. Work with communities, market and provider representatives to establish both minimum standards of adequacy for the delivery system and a process and incentives for encouraging providers to practice within medical shortage areas or areas that do not meet minimum standards of adequacy.

These standards should be based upon the dominant organization of care and the nature of the community and its needs. A guarantee of coverage for services is meaningless unless the delivery system has the capacity to provide those services. The movement towards universal coverage not only implies a benefit package; it also implies a minimum delivery system.

When systems are in transition, definitions for adequacy begin to vary. In 1980, the Graduate Medical Education National Advisory Committee projected that the United States would need 79 primary care physicians (Pediatrics, Family Practice, Obstetrics and Gynecology and General Internal Medicine) per 100,000 population in 1990. Studies of staffing patterns in large established high quality HMOs during the 1990s indicate that 56 primary care physicians per 100,000 residents is adequate. The federal government defines an area as medically underserved if it has fewer than 33 primary care physicians per 100,000 residents. In the future, one expert has predicted that HMOs may employ as few as 20 primary care physicians per 100,000 population. Which ratio should the State use to guarantee that every resident has adequate access to primary care: 79, 56, 33 or 20 per 100,000 residents?

The answer is that State may have to use all four. If a fee-for-service system dominates, a fee-for-service standard should be employed. If HMOs dominate, an HMO standard should be employed. If HMOs and fee-for-service are working side by side, a blended standard might

[37] The definition for a medical shortage area would have to be developed. It could be a composite of the federal standards for Medically Underserved Areas or Health Professional Shortage Areas. On the other hand, the standards might need to be more stringent. The shortage area designation should not be co-opted by local providers to protect themselves from change but directed only at areas struggling to maintain a minimum delivery system.

[38] A. Myerson, "The Battle for Hearts and Tonsils: Hospitals Specialize to Enhance Profits," *New York Times*, October 7, 1997, pp. D1., D4.

work. If neither system has a presence - that is, if the delivery system is so minuscule that the designation fee-for-service or HMO is meaningless - then the State may have to respond with a standard for a minimum system, such as the federal standard for medically underserved areas. Finally, if a managed care system can demonstrate that it can meet the primary care needs of its enrollees with fewer than 33 primary care physicians, then that standard should be given provisional approval. The provision is that the residents in the area must find the care acceptable and that the health status of the population must not decline. New Hampshire has approximately 750 primary care physicians for the full population, estimated at 1,138,000 in 1996, for a provider to population ratio of 65/100,000.

The distribution of primary care providers, however, is uneven, with many rural and northern communities coping with shortages and with the majority of primary care physicians working in the larger population centers in the southern part of the State. In addition, adequate numbers and access for the general population may not mean access for vulnerable populations, particularly the disabled or poor for whom a relatively short distance may present a major barrier to care. In a rural community, two miles to care for an elderly person who is unable to drive, or two bus rides in a city for a single mother with children may present significant barriers to care.

Monitoring of the numbers of providers within individual communities or regions, rather than a statewide average is important and adds two critical dimensions to the discussion:

- How should the service area be defined for each of the covered benefits? Should they be defined individually (eg, one for primary care physicians, one for hospital services, etc.), as a package of services (eg, the service area for a licensed HMO), or in terms of the residential distribution of citizens?

- When should the providers be brought to the community, and when should the community be brought to the providers?

The Department of Health and Human Services currently assists areas with primary care provider shortages (as defined by federal standards) through loan repayment and other incentive programs, to attract and keep primary care physicians, nurse practitioners and physician assistants. The Department also assists communities to recruit for these providers through its support of the Recruitment and Retention Center within the Bi-State Primary Care Association.

These same approaches of shortage designation (based on State criteria) - incentives and recruitment services - could be used for all providers (eg, dentists, physicians, nurse practitioners, physician providers, etc.) needed to meet a standard of adequacy for the State's delivery system.

II. Strategies for State Action:

B. Protecting and Empowering Consumers

Participants in the health planning work frequently voiced concerns about having a neutral party to go to with complaints and needing assistance to navigate the appeals process of managed care. Real or perceived threats to the quality of care was another major issue, as was the lack of information to make informed decisions. Some providers saw the ability to form new managed care entities as crucial to maintaining competition and consumer choice.

The health care industry in New Hampshire is undergoing a historic transformation as more people enroll in HMOs and other types of managed care plans. The State saw a 25% increase, from 191,000 to nearly 240,000 members, in underwritten managed care enrollment between 1994 and 1995 and an increase of 18% , from nearly 240,000 to 282,000 members, between 1995 and 1996.[39] In 1996, the underwritten managed care market penetration reached 25%, up from 22% in 1995.[40] When self-funded business is included, New Hampshire's managed care market penetration rose to 39% in 1996.[41] In the small group market that shift has been dramatic - during 1998 HMO enrollment for this population is expected to reach 80 percent. [42] As the shift to managed care was underway, two health insurers in the State established control of 77% of the managed care market in 1996 (CIGNA/HealthSource (46% of the market), and Matthew Thornton (31% of the market). In 1997, Blue Cross/Blue Shield purchased Matthew Thornton. Had that taken place in 1996, their combined market share would have been 50%.[43]) Recently released national data shows that four out of five employers who sponsor health insurance offer only one plan to their employees. [44]

A quick, fair and "user friendly" approach to dispute resolution might decrease some of the tension in the market-driven health care environment. Tracking complaints can establish whether a problem exists and improve quality. Information - the right information - benefits all market participants from the regulator charged with ensuring that an organization is financially stable or that services promised in a contract are delivered to the provider looking for "best practice" methods.

The core strategies in this section are to:

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[39] Foundation for Healthy Communities, *Managed Care Market Analysis, A Northern New England Report,* Concord, NH, 1997, page 7.

[40] Ibid.

[41] Ibid. A national analysis of the managed care market showed that the State's ranking moved from 11th to 2nd highest HMO penetration in the country: *Managed Care Digest Series. HMO-PPO Digest 1996.* Hoechst Marion Roussel, Kansas City, MO, 1996, pp. 16 -17.

[42] J. Lee et al, *An Investigation into the Effects of the New Hampshire Health Insurance Reform Law, RSA* 420-G, Center for Health Economics Research/IMR Health Economics, LLC, New Hampshire Department of Insurance, Concord, NH, December 17, 1997. The authors of this report refer to the "death spiral" of indemnity insurance in the small group market.

[43] Ibid, pp. 20-21.

[44] Op Cit. Centers for Disease Control/National Center for Health Statistics.

1. establish a system for conflict resolution;

2. assure the quality of care;

3. develop a State information infrastructure; and

4. assure the solvency of risk-bearing entities.

1. Conflict Resolution

Mediation

The speedy, fair and impartial resolution of conflict was one of the major issues raised during citizen discussions. Everyone was concerned - consumers, providers and purchasers. Most states rely on the internal grievance procedures of HMOs to resolve the problems that arise.[45] Since the State and the health plans were seen as having vested interests in the outcome of many conflicts, a number of individuals expressed the need for an impartial entity outside of existing State agencies and health plans that would be responsible for mediating the serious conflicts that occur between health plans, consumers and providers.

For the most part, the market has been the model for dealing with complaints. If someone did not like the way they were being treated by their health plan, they would register their disapproval by voting with their feet. They would leave the plan and sign up with another more responsive health plan. There are, of course, other ways to register disapproval. The most important one is voice, the ability to register complaints and grievances, to protest and to apply political pressure.

The consolidation of delivery systems and the restricted choice of health plans available makes leaving more difficult and voice more important than ever before.[46] Mediation is a means of removing tension from within the health care delivery system.

Recommendation 11. Establish an independent mediator, with the authority to make recommendations, for disputes arising among consumers, providers, health insurers and managed care organizations.

Mediation is the least intrusive - and usually least expensive - of a range of alternative dispute resolution techniques. Mediators have no power to force a solution or make a finding. They do

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[45] At least five states - New Jersey, Rhode Island, Connecticut, Texas and Florida - have legislation requiring external review of final denials by managed care organizations. California Governor Wilson's Managed Health Care Improvement Task Force recommended (January 1998) that the state establish an independent, third party review process by the year 2000.

[46] In New Hampshire two entities - Blue Cross Blue Shield of NH/Matthew Thornton Health Plan and CIGNA/HealthSource - dominate the health insurance market. See also Community Health Institute, "New Hampshire Network Survey Report", Department of Health and Human Services, Office of Planning & Research, Concord, NH, September, 1997, for a discussion on the 29 and health and social service networks that have formed or are in the process of forming in New Hampshire.

not preclude legal action. Instead, they derive their power and effectiveness from the fact and the appearance that they are:

- unassailably neutral;
- skilled in the art of communication;
- competent; and
- trustworthy.

Mediation would not replace the appeals process available to individuals receiving services through the Department of Health and Human Services, the grievance procedures available through health plans and insurers, nor the legal options that may be available to consumers or providers. Mediation would be the final option, prior to legal action, to address issues and concerns that consumers and providers consider to be unresolved through the normal grievance process. Records of referrals to and the outcomes of mediation would be available to all parties.

Recommendation 12. Create an independent consumer hotline for complaints regarding health insurance coverage.

The hotline would:

- provide basic information on consumer rights and obligations;
- identify information channels available to the consumer for resolution of complaints, including any appeals and/or grievance procedures available, and information on mediation;
- make referrals to State agencies, when warranted; and
- catalogue and regularly tabulate all complaints to identify patterns of problems and form recommendations for any corrective actions.

A consumer hotline permits careful and consistent monitoring of the tension within the health care delivery system.

2. Assuring Quality of Care

A consistent theme of the health planning work was a concern on the part of virtually all participants that New Hampshire residents receive quality health care services. In addition, there was a consensus that the State should be responsible for assuring that quality. Consumers and providers were concerned that health plans are increasingly under the control of out-of-state interests and that these interests may be unresponsive to New Hampshire community standards of care and access. The pressures to consolidate operations or merge local/regional delivery systems in order to keep their costs competitive could have a similar result.[47]

[47] The controversy surrounding the Manchester community and Optima Health provides an example. The Attorney General's office ruled (March 1998) that Optima officials violated state law on charities by making promises they did

Current New Hampshire governmental quality monitoring functions are limited to organizations registered as Health Maintenance Organizations, Medicaid, and categorical service contractors. There is an absence of State monitoring of self-insured plans which cover an estimated 280,000 residents (while the federal government - through the Employment Retirement Income Security Act (ERISA) - has created significant barriers, these are not insurmountable - see the discussion on pages 53-54).

As insurance plans in New Hampshire have abandoned the trend to vertical integration (ie, acquisition of clinical practices to create a dispersed staff-model health maintenance organization), most providers have contracted with most plans. This makes allocation of a plan's responsibility for a community's health virtually impossible to measure, regardless of the development of more sophisticated outcome measures than currently exist. While the focus of discussion about quality in the health planning work has been on managed care organizations, it is appropriate to focus quality monitoring efforts as much on provider/delivery systems as on health plans.

See also the discussion in Development of an Information Infrastructure for an individual or consumer approach to quality of care (pages 49-51).

The Elements of Quality

For the purpose of this discussion, the Institute of Medicine definition of quality which is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge, is used. Monitoring the quality of care is complex and presents challenges that need to be acknowledged.

The three elements of quality which can be measured include inputs, process and outcomes:

- **Input measures** are those that examine the basic infrastructure of the health care delivery system. They are generally available, measurable, and reliable. Examples include the extent of service availability, the level of training which providers have achieved, the financial viability of health plans, and the operational capacity health plans can demonstrate (eg, scheduling and billing). The fact that the infrastructure exists or meets some accepted standard does not guarantee quality care.

- **Process measures** are those which examine how a system functions, ie, whether a system of care provides the services which it should, and whether it provides them efficiently or adequately. Examples include monitoring a health plan for the percentage of children in the plan who received appropriate immunizations and the number of eligible women who have received pap smears or breast cancer screening at the appropriate ages and intervals. They do not examine the patient outcome which may be associated with that service.

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not keep and changing the mission of Catholic Medical Center and Elliot Hospital without consulting the community (and the State and probate court). See *Boston Globe*, March 11, 1998, p. B5.

- **Outcome measures** are the most complete measures of health care quality and are the most difficult to quantify. In the past, outcome measurement has been largely limited to examination of easily counted events, usually in relation to a particular procedure. Researchers have begun to examine outcomes which are not so easily quantified, taking into account more subjective measures such as differences in overall health status. An increasing awareness of the importance of the role of overall quality of life and client/patient preference as principal measures has improved outcome measurement (quality of life has been discussed in the section on New Hampshire's vision and values pages 5-11). Examples include a patient's description of how she feels (sick or in pain) and whether or not she can perform her normal activities (such as working, shopping and cooking). A successful procedure or delivery of a unit of service is no longer a success if the recipient does not demonstrate an improved quality of life.

Recommendation 13. Promote and participate in an organization which would develop innovative quality monitoring and improvement activities.

Many District Council members believe the organization should be independent of State government and each of the stakeholders in health care across the State, although all should be invited to participate. The organization should not be an extension of the State's regulatory role, although it may serve as an informational and research resource for State government as well as for other health care organizations.

Organizations throughout the State have developed extensive and valuable quality monitoring activities of their own that could provide direction for such a venture. The New Hampshire Foundation for Healthy Communities, founded by the New Hampshire Hospital Association and supported by a broadly representative group of health care providers and health plans, has undertaken a series of quality evaluations for specific clinical problems. The Center for Evaluative Clinical Sciences at the Dartmouth Medical School has long been a national leader in studies of variation of procedure rates across communities.

New Hampshire's businesses, which are the major purchasers of health care services, represent additional important organizations who have their own interest in assuring the quality of health care services. They must balance their concern for the quality of the services which they purchase with their willingness to bear the expense of expanded monitoring. The creation of the New Hampshire Healthcare Purchasers Roundtable is evidence of the active interest of businesses in accessible, affordable and high quality health care for their employees.

The goal of quality assurance is to improve the quality of care, and hence the quality of life, of New Hampshire residents. This cannot happen without the engagement, participation, and cooperation of State agencies, businesses, insurers and health plans, consumers and their families and advocates, and the service providers in New Hampshire.

Recommendation 14. Develop a coordinated monitoring policy for all health care services for which there is current State legislative or regulatory authority.

As in many other states, quality measures are required by and reported to a variety of State agencies in New Hampshire. States are now considering new approaches to configuring State roles and authority, both because of duplication and regulatory gaps in oversight that need to be addressed. In some cases, several State agencies could be monitoring the same providers. This may become more significant in the future if the Department of Insurance extends licensure to Provider Service Organizations (PSOs) and the Medicaid population is moved into managed care.

The policy should include:

- a clear delineation of activities to be monitored by various State agencies, with the intent of eliminating redundancy and barriers to efficient reporting;
- nationally recognized consensus criteria for measurement (eg, HEDIS [Health Plan Employer Data and Information Sets], QISMC [the Quality Improvement System for Managed Care] under development by the Health Care Financing Administration for both Medicaid and Medicare, and the Market Conduct Examiners Handbook currently being developed by the National Association of Insurance Commissioners) should be the predominant means of measurement;
- the capacity to manage and analyze the required data;
- an effective public education system which can reasonably report the findings of monitoring programs; and
- data and information reports which track progress and change over time.

Challenges in Measuring Quality

In summary, despite the demand and need for information on quality, there are challenges to establishing quality monitoring systems.

- There are no measures for all the things which we would like to know.
- It is not currently possible to link process indicators (such as HEDIS) for a health plan with population health outcomes for a community.
- Each health status indicator is affected by a wide spectrum of variables which are not influenced by medical care.
- Monitoring of the quality of health and social services is complex.

- Different technical and professional skills are required for each of the three elements (inputs, processes and outcomes) of quality in order to collect reliable information.

- Health care plans and systems must be responsive to the information which is reported to them.

- Health plans and provider systems may be resistant to State mandated surveillance data systems which are expensive or seen as redundant with their own systems.

See also the discussions on data and information in the sections on Development of an Information Infrastructure and Public Health (pages 46-47 and pages 49-51 and 61).

3. Development of a State Information Infrastructure

Most states, including New Hampshire, do not have information systems capable of monitoring or supporting health reform. Funding, data comparability, and cooperation of providers and insurers will be issues the State must address if it is to construct a viable health care information system.[48]

During the planning work, the District Councils repeatedly stressed the public's need for information that would allow individuals and communities to make informed decisions. Information is pivotal to the ability of consumers to select an appropriate health plan, employers to negotiate a fair price for their health insurance coverage, or providers to determine how their care compares to other providers in their area. Many stressed that the ability of communities to determine what their local health problems are or how successful interventions have been depended upon the kinds of health information available. Most felt that the State should be responsible for developing the information infrastructure.

See also section on Public Health - Core Role 1 - on the need for data collection and analysis (pages 55-58).

Recommendation 15. Develop the capacity to provide data that allows citizens to review the health status of communities and the statewide population; to understand the performance of State and market functions; and to understand the status of community concerns.

State functions include the design of the benefit system, the financing of those benefits, quality, the fiscal solvency of risk-bearing entities and conflict resolution. Cost and quality information is necessary for the proper functioning of markets. Both the State and the market need to recognize and assess the contributions of non-profits and volunteers.

During periods of stability, information needs are minimal. Significant change, however, alters this. In the current market driven health care system, information needs are increased (for markets to work information must be available). Adequate information can reduce some of the

[48] The most appropriate means to collecting data elements - collaboration or regulation and through State staff, external contractors or public/private partnerships - must be determined.

uncertainty and some of the conflict; it may also serve as a substitute for regulation.[49] It can also improve the likelihood that the State will have a health delivery system that most of its citizens want with few of the elements that its citizens do not want.

The new delivery system is driven by market innovations. Markets work well only when the market participants have ready access to reliable and useful information. If the market is to work, information has to be made available to purchasers, consumers and providers of health care that is accurate and that educates while it informs. People have to be able to understand what the information means, and how it can be used. Perhaps more importantly, the information should assist them in making informed decisions. An example of such an attempt is the development of "report cards" for consumers. Unfortunately, early evidence suggests that consumers are not using them to choose health plans, [50] due primarily to the fact that they do not understand the information and its organization, and the presentation ignores the way people make decisions. [51]

Several aspects of the Information Infrastructure place it properly within the jurisdiction of the State. Such information must be publicly available and its collection and presentation must minimize the self-serving interests of any specific participant in the system. In addition, the sharing of information and data between providers, agencies and organizations must be done with due regard for the confidentiality of individual personal records and business proprietary information.

Recommendation 16. Promote the private development of information that helps improve the health status of New Hampshire citizens and the operation of the health care system.

While aspects of the Information Infrastructure are within the State's jurisdiction, there are certain parameters to this role. The State's role is not simply to collect and present information that meets the needs of government. It must also meet the needs for the proper functioning of markets and communities. The State's information system will not and cannot be all inclusive. There are and should be the opportunities for the creation of new data by market and community interests. Indeed, the State should encourage other participants to contribute to new ways of seeing the world and new information that can improve the effectiveness of private participants. The contributions of the Foundation for Healthy Communities and the Foundation for Informed Medical Decision Making are cases in point.

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[49] The Agency for Health Care Policy Research (AHCPR), in their report "Better Quality Can Cost Less", suggests that objective, scientifically sound and widely disseminated information can have a dramatic effect on the marketplace - encouraging better, more cost effective care without burdensome government regulation.

[50] J. Hibbard and J. Jewett, "Will Quality Report Cards Help Consumers?", *Health Affairs*, vol. 16, no. 3, pp. 218-228. See also J. Hibbard, P. Slovic and J. Jewett, "Informing Consumer Decisions in Health Care: Implications from Decision-making Research", *Milbank Quarterly*, vol. 75, no. 3, September 1997.

[51] In a 1997 report issued by Minnesota Consumers Organized Acting Together (COACT), "Strangled Competition II: The Quality of Health Care Under Managed Competition - The Promise and the Reality", report cards were determined to be "... financially infeasible, too broad in scope and lacking specific information on illness and providers." This group also criticized the 1995 Consumer Satisfaction Survey - produced by the Minnesota Health Data Institute - which ranked health plans as "... being useless to consumers...[it] did not contain cost data, benefit information or information on quality of care for a single illness or condition."

See also the discussions and recommendations on public/private partnerships for data and information collection, analysis and dissemination in the sections on Quality Assurance (pages 45-47) and Public Health (pages 57-61).

4. Assuring the Solvency of Risk-Bearing Entities

The Department of Insurance (DOI) requires that all health plans that assume any financial risk set aside money for unexpected losses. This assures consumers and providers that insurers will honor their promises to pay for services. During the planning process, the fiscal solvency requirements were referred to indirectly. They were discussed as burdensome barriers that prevented the system from moving on to what was really important. These fiscal requirements were broached at District Council meetings and focus groups in terms of provider difficulties or fears. Providers found it difficult to create local networks that met these requirements and expressed concern that they would be unable to bid on the Medicaid managed care contract because they were not an HMO.

The changing nature of the delivery system presents three basic fiscal solvency issues:

- How should the State treat new health care organizations?
- How should the State control the efforts of licensed risk bearing entities to shift risk onto subcontractors (eg, an HMO shifting risk onto hospitals and physicians)?
- How should the State assist individuals when self-insured employer-sponsored plans that are not subject to State regulation collapse?

As new organizations proliferate and old ones are repackaged, the consumer's exposure to financial risk is magnified. Can the new entities deliver on their promises of care? In a market that places a premium on selecting the healthiest patients in the population, will the organizations with the sickest patients be able to pay for all of their care? Or, will individuals who thought they were insured, find themselves ill, facing financial ruin and unable to purchase the care they need?

New Health Care Organizations

New health care organizations without any performance history are being formed on what seems like a daily basis. Insurers and providers are raiding the alphabet in an outpouring of acronyms to describe new arrangements. In addition to HMOs, providers and insurers are organizing themselves into Provider Sponsored Organizations (PSOs), Integrated Delivery Networks (ISNs) and many other entities that claim to be distinct health care organizations. Some - like the HMOs - are clearly identified in State law, while most are not. [52]

New Hampshire's insurance laws provide for the licensing and regulation of entities offering health care insurance. These entities include commercial insurance companies, nonprofit health

[52] The 1997 Balanced Budget Act allowed for the creation of Medicare PSOs which could begin operation as early as 1999.

service corporations and health maintenance organizations. The Commissioner of the Department of Insurance also has authorization to license systems of health care delivery and financing on a limited basis or on an exception basis (through RSA 420-B:23).

New Hampshire's Department of Insurance requires all risk bearing entities in the health care field to have at least $6 million in financial reserves. The financial reserve can be considered as consumer protection from health plans that priced their product too low or that underestimated their risk.

Such high reserve requirements not only safeguard consumers; they are also barriers of entry into the insurance field. As the reserves increase, the financial demands on firms that want to sell their product in New Hampshire also increase. Smaller businesses may thereby be excluded from the market.

A new organization that wishes to assume risk is itself a risky proposition that warrants regulation. While the justification for the regulation is clear, the question before the Department of Insurance is whether the specific levels and amount of the financial reserves are so high that they are stifling the creation of new, viable and relatively safe businesses.

Recommendation 17. Establish licensure for health care organizations that bear financial risk based on a formula that adjusts capital and reserve requirements to the number of covered lives served by an organization, its structure, and the percent of risk that the organization will assume.

The National Association of Insurance Commissioners (NAIC) has taken a position that risk is not constant - it varies. NAIC has been developing a formula that would adjust capital and premium set asides to the number of covered lives served by an organization, its structure and the percent of risk that the organization has assumed. This is the NAIC's first attempt to recommend capital and reserve requirements for all risk assuming entities: insurance companies, HMOs and all of the health care organizations entering the market.

NAIC began to test the formula in a select number of states during the summer of 1997. New Hampshire was one of those states. The New Hampshire Insurance Department has worked to simulate the impact that the NAIC risk based formula would have on several health care organizations in the State. The Department has also indicated a willingness to work with these new organizations to develop alternative licensing standards.

Even with the NAIC adjustments, organizations in rural or medically underserved areas might require assistance or a partial exemption from the financial reserve requirements. The health care systems in rural and medically underserved communities, or which serve the uninsured or underserved, tend to be fragile and can be easily disrupted by the strong external forces of national and regional health maintenance organizations. The legitimate and reasonable concerns that regional health systems have for efficiency, effectiveness and profitability may run counter to the needs that a community has for access, convenience and job security.

The promotion of rural networks and networks targeted at the uninsured or underserved, however, should not impose unnecessary risks on consumers. Protection of the consumer may

mean that alternative methods for financial guarantees need to be developed. This could take two forms:

- private sector joint ventures in which the community network provides the service and the insurance company underwrites the risk; and

- private/public joint ventures in which the State through one of its agencies would re-insure a community enterprise (ie, the State would assume the cost of services that exceed a given threshold of expenses).

Down-Stream Risk

Recommendation 18. Develop guidelines governing the transfer of financial risk from one entity to another.

Another new development in the market driven health care system that can affect consumers and the quality of their care is known as "down-stream risk." Down-stream risk occurs when a licensed risk bearing entity shifts risk onto an organization or provider that is not licensed to assume financial risk. This occurs when a health plan transfers financial risk to providers under contract to the plan. For example, an HMO pays a hospital on a capitated basis (that is, the hospital agrees to provide all services the HMO needs for a fixed fee per person). The hospital, in turn, can transfer some of its risk onto individual doctors (who agree to provide all physician services that the enrollees might need for a fixed price per person). Each transfer creates different kinds of risk with different levels of exposure for both patients and providers.

Some subcontractors can absorb an underwriting risk. They are large institutions with large budgets and large reserves. As you move down the operational chain, however, the providers become smaller and their capacity to take on and absorb underwriting losses diminishes.

The Department of Insurance has an responsibility to assure the quality of care of all risk assuming entities. Down-streaming can affect the ability of a provider to allocate sufficient resources to care for their patients. Therefore, to the extent that risk is moved, the DOI has a corresponding responsibility to assure quality of care.

Self-Insured Employer-Sponsored Plans

With the passage of the Employee Retirement and Income Security Act (ERISA) in 1974, Congress reconfirmed the states authority to regulate insurance plans and Multiple Employer Welfare Associations (MEWAs) while allowing a new class of exemptions - self-insured employer-sponsored health coverage. Nationally, more than 40 percent of all workers are in employer-sponsored self-insured plans.

Self-insurance means that the employer assumes the underwriting risk for their employees and is exempt from State regulation. One of the many troubling aspects of this provision is that no federal requirements replaced the traditional State concerns for quality assurance and fiscal solvency. Since 1989, a number of self-insured New Hampshire plans have failed. The

Department of Insurance has handled the proceedings for self-insured plans that have failed - extending essential services to New Hampshire consumers and providers. These services have included helping all involved parties reach a settlement on outstanding claims and arranging for third party administrators to process claim payments.

Recommendation 19. Establish the capacity to track the numbers of self-insured plans, require such plans to disclose to their enrollees that they are self-insured, and provide support and guidance to individuals insured under such plans.

Implementation of this recommendation would provide the basis for:

- an annual determination of the number of self-insured plans and individuals covered by those plans. This would permit the determination of the number of employees covered under self-insured plans and the circumstances that prompt employers to be come self-insured under the Employment Retirement Income Security Act of 1974;

- mandatory disclosure by self-insured plans to inform their employees that the Employment Retirement Income Security Act (ERISA) does not require the employer to meet the State's financial reserve requirements, State mandated benefits, State quality assurance standards for health plans and consumer protection provisions. Many individuals are unaware that the plans they belong to are operated outside of the jurisdiction of the State and that the State cannot assist them. At a minimum the workers of New Hampshire should know and understand that their self-insured plans are not regulated or protected by the State of New Hampshire;

- a hotline for employees in self-insured plans to record the problems encountered within these plans. Since the State, providers and individuals assume the costs of failed self-insured health plans, the State should track how well or badly those firms are doing and whether the State needs to make new provisions for whatever new problems are developing; and

- a waiver to the Employment Retirement Income Security Act (ERISA) that would permit the Department of Insurance to work with consumers to resolve complaints against self-insured plans.

It is important to note that the Department of Insurance treats any efforts by self-insured plans to shift risk onto providers (the down-streaming discussed above) as bringing that portion of the plan into the State's jurisdiction. When an employer transfers the risk of excess medical expense associated with its employee benefit plan to a licensed insurer, that benefit plan is then treated under ERISA as a fully insured plan. That plan is then subject to State insurance regulation (policy forms, mandated benefits, premium rates, unfair trade practices, solvency requirements; taxation and other matters).

II. Strategies for State Action:

C. Re-Defining Public Health In the Evolving System

> *Public health agencies are a lot like fire departments. They teach and practice prevention at the same time that they maintain readiness to take on emergencies. They are most appreciated when they respond to emergencies. They are most successful - and least noticed - when their prevention measures work the best. In another respect, the two are different. Everyone knows what a fire department does; few know what a public health department does. The very existence of health departments is testament to the fact that, when legislators, county commissioners, and other policymakers understand what those departments do, they support them. It is a rare person who, once familiar with the day-to-day activities of a public health department, would want to live in a community without a good one.*
>
> Source: Washington State Department of Health, 1994.

Public health services are population-based - that is, they "treat" the whole population instead of the individual as is the case of personal health services. An example of public health (population-based services) would be a campaign on the importance of physical activity for all the residents in New Hampshire or Manchester or all the students at the University of New Hampshire. This differs from individual or personal health services, such as a visit to a provider for a physical exam or instruction on how to follow a diabetic diet. Most people probably do not even think of "public health" when they eat at a local restaurant, read a newspaper article on teenage smoking or listen to a public service announcement on wearing seat belts. Yet restaurant inspection, the collection and analysis of epidemiological data and public education on injury prevention are all examples of public health functions (a more complete discussion of public health roles follows under The Ten Core Roles of Public Health).

During the health care planning work, participants indicated that State government should continue to be responsible for maintaining public health functions. As the delivery system is transformed, it may also be transforming public health. The following needs to resolved:

- the re-definition of public health;
- the determination of the impact that private and community reorganization of health care services have on public health;
- the decision on which public health functions should remain, be expanded, altered or eliminated in light of private and community reorganization of health care services; and

The federal Centers for Disease Control and Prevention and a variety of public health organizations have developed ten core roles for public health agencies in Table 4. Fulfilling these roles presents a number of challenges in the changing delivery system.

Table 4

The Ten Core Roles For Public Health

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Turncock and Handler, 1995.

Some of the roles are historical responsibilities for public health agencies (eg, diagnosis and investigation of community health problems and the identification of health hazards), while others have become public health responsibilities by default, in response to failures in the health care delivery system (eg, linkage to personal health services and assurance of the provision of health care when otherwise not available). Others are clearly roles which have been and must continue to be shared by public and private entities (eg, evaluation of the effectiveness, accessibility, and quality of personal and population-based health services).

The ability of state and local public health agencies to fulfill the ten core roles varies considerably. Examination of capacity has indicated that it is partly determined by the ways public health agencies work with and gather support from the private sector and communities.[53] Capacity also depends on the dollars available to agencies for the provision of public health core functions. While approximately 1.6 - 2.7 percent of national health expenditures go to fund public health programs (that is 16 to 27 billion dollars), more than two-thirds of those dollars are

[53] P. Halverson, "Performing Public Health Functions: The Perceived Contribution of Public Health and Other Community Agencies", *Journal of Health and Human Services Administration*, vol. 18, no. 3, 1996, p.288.

spent on the financing or direct provision of clinical and social services.[54] In the new health care system, the allocation to public health services may be inadequate or excessive depending upon how public health roles are altered.

Recommendation 20. Collaborate with the Turning Point Steering Committee to reassess the functions of public health.

New Hampshire was one of fourteen states to be awarded a grant through the Robert Wood Johnson and the Kellogg Foundation's "Turning Point" initiative. The purpose of this initiative is to assist states in determining what the roles of public health will be in the 21st century and who will be responsible for carrying out those roles. Members of the Turning Point Initiative include the Department of Health and Human Services (DHHS), the Department of Education, the Department of Environmental Services, the NH Public Health Association, legislative representatives, the NH Municipal Association, the NH Medical Society, the NH Health Care Purchaser's Roundtable, Blue Cross and Blue Shield of New Hampshire, and representatives from three communities (Nashua, Manchester and Franklin). Much remains to be decided in the next several years, particularly what infrastructure needs to be in place at the State and local levels. This is an opportunity for State/local and public/private dialogue and decision-making around activities aimed at implementing the core public health roles in the future health care system.

The Ten Core Roles for Public Health

Recommendations for New Hampshire are presented at the beginning of the discussion on each of the ten core public health roles. The recommendations focus on determining the extent of the problem, the current capacity of all providers to respond to that problem, and steps to remedy the situation. Decisions on the proposals and recommendations should be based on a broad consensus model like that used in the Health Care Planning Process: with the involvement of stakeholder organizations, professional experts, and the State. As suggested above, the Turning Point initiative provides that vehicle.

1. Monitoring health status to identify and solve community health problems.

See Recommendation 15 - Development of a State Information Infrastructure - (page 49-50).

Monitoring health status was discussed at some length during the development of the *Health Status Indicator Inventory*. The Department of Health and Human Services has consistently collected and reported a range of health data sets for specific areas of interest (e.g., the Cancer Registry and the Behavioral Risk Factor Survey). The DHHS has also developed the *Primary Care Access Data* which has been used statewide in conducting local needs assessments. A variety of other organizations are also involved in the collection and analysis of population-based data, such as the New Hampshire Hospital Association (the Uniform Hospital Discharge Data

[54] "Estimated Expenditures for Core Public Health Functions - Selected States October 1992 - September 1993", MMWR, no. 44, vol. 421, 1995. See also R. Brown, A. Elixhauser, et al, National Expenditures for Health Promotion and Disease Prevention Activities in the United States, Battelle Medical Technology Assessment and Policy Research Center, Washington, DC, 1991.

Set), the Department of Education (the Youth Risk Behavior Survey), the Children's Alliance (The Kids Count), and the Center for Evaluative and Clinical Sciences at the Dartmouth Medical School.

In consultation with external experts, a consensus should be developed on the extent and type of population health measurement efforts required, ie, whether to maintain the current level of activity, provide expanded and more flexible analyses of currently available data sets, or add data sets which are identified as important to understanding the health status of New Hampshire's population. The decisions should be based on the resources, existing data sets, and methodologies available.

One possible solution - a Health Data Consortium - would address some of these issues. The Consortium could serve as a resource for information sharing; as a clearinghouse by a variety of organizations; and as a forum for discussion of data policy issues across a broad range of disciplines. It could also serve as a focus to attract funding for statewide data initiatives. The Consortium should not, however, be expected to preclude the need for the State to finance data and research activities which by consensus are assumed to be State public health responsibilities.

See also the discussions on data and information in the section on Quality Assurance (pages 45-50).

2. Diagnosing and investigating health hazards in the community.

Recommendation 21. Determine whether current baseline monitoring efforts are adequate or should be expanded to monitor health risks and outbreaks.

These activities can be categorized into three areas:

- investigation of outbreaks;
- monitoring of chronic or potential hazards to health, particularly environmental and occupational risks; and
- analysis of population-based data sets (as noted above).

The Department of Health and Human Services currently has the capacity and expertise to investigate acute outbreaks and take appropriate action. One area which may be of concern is the ability to monitor new or developing public health risks. The DHHS has participated in an evaluation of health risks caused by environmental factors in conjunction with the New Hampshire Comparative Risk Project and is seeking to develop a similar capacity for work-related injuries and illness. It should be determined whether this level of cooperation between public agencies and between public and private agencies is adequate or should be further expanded to track new and emerging threats to the health of the public.

The DHHS should also work in cooperation with statewide organizations to explore the feasibility of expanding capacity to perform these public health functions at the local level

(including the health officer liaison program). The "Turning Point" Initiative will provide preliminary direction for developing this dialog and capacity.

3. Inform and educate people about health issues.

Recommendation 22. Implement improved coordination of health promotion and wellness activities across government agencies, managed care, and other public and private organizations.

New Hampshire has seen substantial activity by public and private agencies and organizations in the area of health promotion and wellness. Many organizations provide the same or similar information in different formats and settings, targeted at specific populations (eg, teenagers) and specific health issues (eg, smoking). Overall coordination would ensure that the messages and information are compatible or that important health education/health promotion messages are available to all populations. The DHHS needs to re-evaluate its own health promotion activities in light of the increased private sector participation in health promotion projects; this may also be facilitated by the "Turning Point" initiative.

4. Mobilization of community partnerships and action to identify and solve health problems.

5. Development of policies and plans that support individual and community health efforts.

See Recommendation 25 - Partnering with Communities - (pages 62-70).

It is in the public interest to provide technical assistance which includes a strong public health orientation. New Hampshire has a long tradition of strong community control and identity and has relied on local initiatives for many of its health system decisions. For example, the Primary Care Initiative (which led to the establishment of community health centers) was an effort initiated by State government in which decisions were made at the local level. The DHHS supports local decision making by providing technical assistance and resources and by seeking out federal support for local efforts.

6. Enforce laws and regulations that protect health and ensure safety.

This function applies to the implementation of the other nine core roles.

7. Linking of people to needed clinical and social services and assurance of the provision of health care when otherwise unavailable.

The Department of Health and Human Services finances a large number of clinical and social services for individuals who are uninsured or underinsured and not able to receive care through the private health care system. These are services that are provided because of failures or inadequacies in the public and private systems. In a perfect world - one in which universal coverage was assured for all citizens for all needed health and social services - public health

would not be involved in these services. In the new health care system, if the need for safety net clinical and social services increased dramatically and the State chose to fund these services, other public health functions critical to the new system might be ignored or underfunded.

See also the discussion on Safety Net Providers and Delivery Structures (pages 37-40).

8. Assurance of a competent public health and personal health care workforce.

Recommendation 23. Determine the level of support which the State and private entities (such as managed care organizations) ought to provide to public and private health care provider training programs.

This determination should be based on the projected needs of the population. One result of the changes in the organization of health care has been the reduced willingness of provider systems to fund educational/training activities for health care professionals and for research needed to understand and meet the health care needs of the population. Population-based health education has traditionally been under-emphasized in health professional training but if the benefits of managed care are to be realized, providers will have to play a stronger role in educating the general public. Promoting and sustaining population-based education for health and social service professionals is a key public health issue.

The State plays an important role in the training of some health and social services professionals through the University of New Hampshire. In addition, it provides limited targeted assistance to the New Hampshire/Dartmouth Family Practice programs and the Office of Generalist Education at Dartmouth Medical School. Community Health Centers have provided opportunities for primary care education, which will expand with the federally funded statewide Area Health Education Center (AHEC) program - a program targeted to the development of community based professional education.

9. Evaluation of the effectiveness, accessibility, and quality of personal and population-based health services.

In 1996, 39% of New Hampshire's population was enrolled in HMOs (includes underwritten managed care and self funded business). Two current MCOs (CIGNA/HealthSource and Blue Cross/Blue Shield, who purchased Matthew Thornton in 1997) accounted for 77% of HMO enrollees in 1996. One of the major differences between indemnity insurance and HMOs is that the former makes a commitment only to pay for health care, the latter is obligated to both pay for the care and arrange for the delivery of that care. The health status of enrollees in an HMO becomes a critical determinant to the financial success of an HMO. As the portion of the population enrolled in HMOs increases, the work of HMOs and public health may overlap. Since the State's residents are rapidly choosing to receive care from two HMOs, these HMOs can - and some would argue should - offer some population-based services that were traditionally provided by public health. In addition, these HMOs might also perform some of the public health evaluations of the effectiveness, accessibility and quality of personal and population-based services. The Turning Point project is a vehicle for considering these changes.

This role was discussed in the section on Quality (pages 45-49).

10. Research for new insights and innovative solutions to health problems.

Recommendation 24. Determine the critical areas for public health and policy research and establish criteria for public and private funding.

Concerns have been expressed nationally about the unwillingness or inability of private institutions to support health care research. Emphasis on cost competitiveness and increasing market pressures have forced these institutions to reduce or abandon many of these activities. In the discussion of public health roles, a principal concern is the maintenance of the ability to conduct core research that is in the public interest.

New Hampshire has a variety of organizations which have been established to address the scientific and policy issues for aspects of the health care system. They include the Healthy Communities Foundation established by the New Hampshire Hospital Association, the New Hampshire Public Health Association, the School of Health and Human Services at the University of New Hampshire, the Center for Evaluative and Clinical Sciences at Dartmouth Medical School, and the Department's Office of Planning and Research. The Health Care Transition Fund Community Grant Program has provided an opportunity for a variety of organizations in the State to explore new research and service delivery options.

The development of the *Health Status Indicator Inventory* has raised important questions about the availability of some information and the ability to measure some elements identified as important. There has been an ongoing concern for the need to address all the determinants of health, including the more subjective contributors: safety, social supports, and independence. Research will be needed to develop the factors and methods to collect this data.

II. Strategies for State Action:

D. Partnering with Communities

District Council members and other participants in the planning work frequently stressed the need for making the voice and the needs of the community an integral part of the new health care system. These discussions raised two basic questions about both communities and the State's involvement:

- What is a community? What is it that the State should be listening to and promoting?
- Why should the State support community involvement in the health care system?

When these questions are fully answered through the planning work, the State can begin to consider how it should assist communities and what form the assistance should take. The State can also determine what it can expect from communities: the way they can balance and augment the actions of the State and the market. This would also allow the State to work with communities to clarify expectations for private entities that claim a community role. For example, non-profit hospitals are described as community organizations that provide community benefits. In return, these institutions do not pay taxes. However, neither the State nor other independent body representing communities has defined the community benefits that non-profits should be providing.

This section discusses:

- The Definition of Community;
- Importance of Community to the Health Care System;
- Limits of Community;
- The Benefits of Community Discussion;
- Sustaining Community Involvement in the Health Care Delivery System; and
- Defining and Protecting Community Benefits.

Formal and informal community systems of care can be disrupted or destroyed by the actions of government or the competitive nature of markets. The same coordinated and collaborative approaches outlined in the previous sections of this report are used here to propose ways the State can support communities in delivering health care services. The strategies and initiatives are designed to foster community innovation, community participation in the development of health care policy and a common understanding of what constitutes community benefits.

The core strategies in this section are to:

1. sustain community involvement in health care delivery, and

2. define and protect community benefits.

The Definition of Community

"Community" has a number of definitions. In its loosest form, a community is a group of individuals with shared characteristics (eg, children, the developmentally disabled, health care providers, and the uninsured). As the idea of community becomes more refined, it involves shared space (eg, the residents of Manchester or the students at any school in the state). In its most sophisticated form, a community involves shared space, interests, language, rights, obligations, values, institutions, resources and world view.

The planning work has focused on communities and community activities that meet three criteria:

1. communities that are webs of social relationships that encompass shared meanings and above all shared values;

2. communities whose members interact on an informal basis; and

3. community activities that are neither dictated by government nor purely a market response.

Within the focus groups and District Council meetings, the involvement of two types of communities were often stressed that meet all of these criteria:

1. local geographic communities that sometimes means towns or cities, and sometimes entire regions, such as the "North Country", and

2. the communities of populations that share common characteristics or needs and who may be drawn into local, regional or statewide associations to provide support to each other and to address common issues and concerns.

The Importance of Communities to the Health Care System

District Council members and participants in the planning process frequently stressed the need for making the voice and the needs of the community an integral part of the evolving health care system. These needs are distinct from the functions and operations of government or the market. Communities are vulnerable to and can be overwhelmed by the power of both government and markets.

The community is often represented by individuals, agencies and firms with complex agendas. Specifically, these representatives of the community can be seen in operation in local government, local business, non-profit agencies and organizations, and as volunteers. They promote their own economic or professional self-interest and the interests of the communities; or

represent government's demands as well as their own personal commitment to the well being of the community.

Communities, and organizations representing their communities, demonstrate their absolute or relative importance to the health care system in at least ten ways. Each of these ways was discussed directly or indirectly by the District Councils, during the town forums, and by the focus groups as important reasons for partnering with communities in the development of the health care delivery system. For the most part, these attributes of communities can apply to communities as both geographic entities and associations of individuals who share common characteristics.

1. **Communities represent values that are not necessarily parts of market or government.** In simplistic terms, the best of government may be personified as the proper use of authority, the best of the market as the efficient allocation of wealth and the best of the community as the sweetness of life: compassion, commitment, belonging, forgiveness, trust, loyalty, affection and love.

2. **Some community values and concerns are in direct conflict with markets and government.** For example, from a community perspective, a sick uninsured individual who cannot afford care is not the natural result of demand and supply or a by-product of government's budgetary constraints. The person is a friend or a neighbor whose pain is real within the context of community in a way that is not feasible within the context of government or market.

3. **Communities embody a knowledge of local conditions that are often impossible to incorporate in government procedures and are of no monetary value to the market.** Family members and friends provide much of the care for elders in this country and the individuals providing this care are aware of the unique personal needs of those they are helping. Many elderly patients do not have the financial wherewithal to purchase this care in the market, and state government is unable to track and respond to all individual's unique needs.

4. **Communities provide goods and services that would otherwise be the responsibility of government.** Community action, such as physician services provided through a church group or social services provided through a non-profit women's shelter, can replace services that government would otherwise have been required to provide.

5. **Communities offer a solution to the need for consumer education.**

6. **Communities provide goods and services that are unprofitable and beyond the scope of government but are essential to the well-being of individuals and the overall community.** Religious groups that do home visiting and volunteers who provide transportation to medical appointments which are not specifically part of a needed medical service are taking the extraordinary step of attending to the well-being of the person and the community.

7. **Communities provide needed goods and services free or below market prices. The millions of dollars of non-reimbursed care that New Hampshire health and social service providers give each year are vital community actions.** Those charitable services would not be available if the providers were solely concerned with maximizing their income.

8. **Communities provide the same goods or services that the market or government provide but do it in a way that reflects the non-market and non-government values of the community.** For example, a non-profit social service agency may provide the identical care as a proprietary entity in the same community. For many of its clients, however, the non-profit agency's relationship with the community is critically important: it is recognized and accepted as a part of the neighborhood and is managed and staffed by neighbors.

9. **Communities are concerned with the general physical, social and economic well being of local residents.** When the community endorses a specific health care action - such as the creation of a local clinic - it does so with an eye to broader concerns. Will it increase jobs? Will the money generated within the clinic circulate within the community? Will the clinic make the community more attractive to potential businesses or residents? Will the clinic enhance a sense of community solidarity (ie, will it care for the poor as well as the affluent and insured)? All of these actions work towards building the community.

10. **Communities can contribute to social cohesion which improves the health of community members.** Communities with high levels of trust, tight social cohesion and low levels of income disparity tend to have lower mortality rates and less illness than those communities characterized by mutual mistrust, minimum social interaction and great differences in income among its members.[55]

The Limits of Communities

Discussions of communities generally reflected the positive effects that communities can have for their members. However, when discussions became more specific, caveats began to emerge related to the limited perspectives and resources of communities. Thus, while community needs and concerns were always a part of the discussions that took place during the planning work, very rarely did anyone suggest that the "community," in the geographic sense, should control the local health care system, or that, in the population sense, "communities" be viewed as the sole source of information and input for its members. Most participants in the health planning work supported limited and directed community involvement: a community partnership with the State on specific local programs, preferential treatment of local provider based networks or local control over delivery systems affecting specific groups (eg, the developmentally disabled). The range of limitations raised included these points:

[55] From a public health perspective, New Hampshire has the good fortune of having comparatively high levels of trust, low levels of income disparity and low levels of mortality rates. I. Kawachi, B. Kennedy, and K. Lochner, "Long Live Community: Social Capital as Public Health", *The American Prospect,* November/December 1997, pp.56-59.

- there are insufficient resources within communities to set up and monitor a comprehensive system of health care;

- a lack of appropriate leadership accountable to community member;[56]

- disparities in the resources from community to community that would lead to inequities in availability of care; and

- communities could become instruments of intolerance should control become concentrated in a few hands, leading to punitive policies directed at selected populations within a geographic community (eg, homosexuals and minorities) or within a community of individuals with shared interests or needs (eg, favoring particular courses of action or care not appropriate to the needs of all members).

Associated with the limitations of communities was the concern that community needs assessments could become dominated by providers and provider agencies that do not understand all of a community's needs or who have intentions that are not shared by the full community. A frequently cited example was physician or hospital dominance in discussions on the health-related non-medical needs of communities.

Not only were the limitations discussed; there was also a call to place limits on community actions, such as:

- a desire that personal decisions and choices on health care and lifestyle be free from judgments that reflect the prevailing standards of the community, and

- communities should not control goods, services, rights or obligations that should apply uniformly to all citizens within the State. [57]

[56] Particular concerns were expressed over the ability of local governments to manage the delivery of health care services. Even though local governments were not seen as the answer, individuals could not come up with an entity outside of government (eg, a locally formed network) that they would assign that function.

[57] There was disagreement on this point among those who viewed local government as having a role in protecting the public's health, a point which was generally conceded by those who raised the objection. Those who held this view argued that a municipality's "public health" role and the delivery of health care services to individuals were distinct and discrete, and that the operation of a care delivery system was not an appropriate responsibility for local government.

1. Sustain Community Involvement in Health Care Delivery

Changes in New Hampshire's health care and social service delivery system were already under way at the community level, when the national debate on health care reform began. The deinstitutionalization of mental health services, the development of area agencies for the delivery of services to people with developmental disabilities, the efforts to develop family centered children's services, and a shifting of focus from categorical[58] health care delivery to the delivery of primary care services within a community-based comprehensive care setting predate the recent national health care reform debate. They reflect the efforts of communities to identify better ways of providing services.

Non-profit agencies, advocates for specific population-based communities, and local providers have been instrumental in developing alternative service delivery mechanisms needed to meet the needs of community members in a way that takes the whole person, family and improvement of the community into consideration.

The early and ongoing movement toward a community-based delivery of mental health care services, primary health care services, services for people with developmental disabilities, and the relatively recent movement toward the development of networks and non-institutional services for the elderly, largely reflects two trends:

- the quest to improve the availability of services to all of the members of a community in a way that reflects family and individual needs, as well as community values, and

- the need to meet the challenges of the evolving health care delivery system, which includes both diminished funding and the emergence of managed care.

As discussed above, communities may lack resources and expertise. On the other hand, they have an important role in the health care system - and as New Hampshire's experience has shown - no lack of ideas and committed citizens. Financial and technical support is necessary to develop and sustain new and innovative community-based approaches.

Recommendation 25. Maintain and protect the Health Care Transition Fund to support innovations in the delivery of health and social services.

State government, and the Department of Health and Human Services in particular, should continue to support the rich tradition of community involvement in meeting the needs of their members. This can be done by offering technical assistance and funding opportunities for community planning activities that include the development of community-focused goals and objectives and new service related initiatives. The New Hampshire Health Care Planning Process has provided an opportunity for individual and community participation and comment in the development of public policies covering a broad range of issues. Part of this effort includes the projects sponsored by the Health Care Transition Fund Community Grant Program.

[58] A health service or program restricted to a single population (eg, child health clinics or screening women for breast cancer) due to State or federal funding requirements.

One of the positive aspects of the Health Care Transition Fund (HCTF) Community Grant Program has been the opportunity for communities to work together and with other State agencies to share ideas, data and innovations that address the health of communities. Some recipients have encouraged the Department to expand its role to include assistance in securing ongoing funding and adoption of those innovations that offer promise in meeting the Department's objectives.

An independent evaluation of the first year of grants awarded by the HCTF Community Grant Program indicates that the projects were successful in addressing the goals of the Program.[59] By encouraging innovation in the design and delivery of services; in needs assessment and evaluation of service delivery; and in addressing unmet or emerging health concerns, the Department has supported the importance of community-based solutions. Three notable findings from the evaluation are:

- HCTF resources have been effectively leveraged - examples include the $510,000 Network Development Grant from the Federal Office of Rural Health Policy (Littleton-Berlin areas); the $480,000 Turning Point grant from the Robert Wood Johnson and Kellogg Foundations (to the NH Public Health Association) and the US Public Health Services grant awarded to the Community Health Access Network (CHAN - an administrative/management network of community health centers).

- Research projects have generated tools and quality-based outcome measures that are available to other community providers to monitor performance and improve quality.

- Grantees have demonstrated a high level of commitment to project continuation (this has been attributed to the fact that the Community Grant Program encouraged innovative and creative proposals to meet local needs).

See also APPENDIX B for a discussion of the Health Care Transition Fund Community Grant Program projects.

[59] Health Care Transition Fund Community Grant Program: Evaluation of First Round Grantees; Community Health Institute, January 1998.

Benefits of Community Discussion

When the members of the District Councils were queried regarding the value to them and their organizations of participating in the planning work that resulted in this and the other reports, they acknowledged that the process has been beneficial because it provided a forum for:

- **Communication and Networking.** Participants value the opportunity to meet and get to know other individuals and agencies committed to addressing the health care needs of the community.

- **Input from Diverse Perspectives.** Broad participation of many constituencies brings diverse perspectives that are helpful in identifying and addressing local needs.

- **Reality Testing.** Participants learn about the realities/constraints under which local communities and the State operate. As a result, participants are more sensitive to the complexities under which the State operates which impact public policy development.

- **Learning about State Initiatives/Directions.** Participants are better able to position their agencies if they have a "macro view". That is, they are familiar with the direction in which State policy makers are heading.

- **Communication between Community and State.** The work provides a vehicle for regular two-way communication between the State and community which contributes to greater familiarity with the specific circumstances in the regions as well as with many of the agencies working to meet local needs. In particular, it ensures that a regional perspective is reflected in State policy decisions.

- **Joint Problem-Solving.** Participants engaged in discussions with State policy makers to identify, prioritize, and strategize about issues and problems facing local communities and the State.

- **Input in Public Policy Development.** Participants welcomed the opportunity to have input into formulation of public policy by communicating a local perspective, advocating for the needs of the community, and expressing local preferences for policy options.

- **Time and Attention Dedicated to the Process.** The fact that the State devoted significant resources and time to the process assured participants that their concerns were respected and that their needs will be considered in public policy development and future decision-making.

As the DHHS discusses this document with other stakeholders for review and revision, the above benefits of participation should be duplicated. Some of these stakeholders may participate in the long-term effort by becoming members of the re-designed District Councils, adding to the diversity of input, the "reality testing", and joint problem-solving. Others may become part of an advisory group to the Department of Health and Social Services, the Department of Insurance and the Attorney General's Office for the purpose of monitoring and responding to market behavior.

District Councils

Recommendation 26. Retain the District Councils as a permanent part of health planning and policy development.

The community planning process should continue and the range of functions of the District Councils should include:[60]

- providing a forum for community planning participants to meet regularly and to network;
- providing a forum for community representatives and State policy makers to learn about the realities/constraints under which communities and the State operate; to learn about State and local directions and the needs of various population groups; and to identify opportunities for addressing local and statewide problems;
- providing input into formulation of public policy by giving community planning participants the opportunity to communicate a local perspective, to advocate for the special needs of members and residents, to express preferences and to identify population-specific and region-specific needs and constraints;
- providing feedback regarding implications for the region or population of proposed initiatives;
- assisting in identifying feasible and realistic strategies which employ local or available resources to achieve goals;
- advocating for the community at the State level to support the successful implementation of broad goals and objectives;
- monitoring and providing feedback to the State regarding the impact of public policy on the community and the degree to which intended outcomes are being met;
- serving as a liaison and advocate between the State and the communities by sharing information; and
- facilitating "buy-in" by the community in implementing goals and objectives.

These District Council participants did not, however, envision a role for the community based planning effort in direct implementation of the strategies. The group anticipated an oversight role - monitoring the impact of State and local response and providing feedback regarding the status of implementation efforts.

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[60] These recommended functions were drawn from the District Council discussions of October 1997, that was facilitated by Susan Friedrich of the Community Health Institute and reported in *Components of a Community-Based Planning Process* dated November 1, 1997.

2. Define and Protect Community Benefits

Recommendation 27. Develop operational standards for community benefits (with representatives from communities, non-profit providers, and representatives from the Department of Insurance and the Office of the Attorney General) that reflect community values.

Non-profit organizations have historically dominated the hospital sector, health maintenance organizations and social service organizations. A non-profit organization may be owned and controlled by those who use it (the members) or may be a mutual[61]: (a company with a non-membership self-perpetuating board). The primary distinction between a non-profit and a for-profit firm is the that non-profit cannot distribute net earnings (or any increase in its net worth) to individuals who exercise control over the entity. Non-profits receive a sizable public subsidy in the form of tax forgiveness. They are exempt from federal income tax, state and local income taxes, sales tax and property tax. Non-profits are eligible for specific tax free bonds. They also receive preferential tax treatment for charitable gifts (that is, when the non-profit receives donations, the donor may claim those gifts as a tax deduction).

The general public often makes two false assumptions about non-profits. The first is that they cannot make a profit. In fact, non-profits can generate profits as long as they direct the proceeds back into the services that meet the mission of the organization.[62] The second misconception is that non-profits have to provide charitable services. For most non-profits in the health care field - those who have 501(c)(3) tax status - all the services have to be legal and in accordance with "religious, charitable, scientific, testing for public safety, literary, or educational purposes." Charity would be nice but is not explicitly required.[63]

Non-profits have been viewed as essential in health care because many believe that non-profits derive their rewards by embodying the principles of altruism, compassion and service. The belief is that they offer services to the community that would not be made available by proprietary firms. While that belief tends to be supported by assessments of the non-profits' contributions to their communities, that experience is not uniform. There are instances when proprietary firms provide more benefits to their communities than non-profit institutions.

This blurring of community contributions originates with the dual function of non-profits. They are both community organizations and economic entities. Money matters to their survival. If the resources are not available, the non-profit will not be able to meet its mission. Therefore, non-profits represent a hybrid entity; one that is assumed to primarily serve the community while also operating as a seller in the market that competes with other non-profit, proprietary and government firms.

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[61] A mutual is a form of corporate organization without stockholders, in which members proportionately share profits or losses, expenses, etc.

[62] Bradford Gray (ed.), *For-Profit Enterprise in Health Care,* Institute of Medicine, Washington, DC, National Academy Press, 1986, p. 8.

[63] Mark Schlesinger, Bradford Gray and Elizabeth Bradley, "Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System," *Journal of Health Politics, Policy and Law,* Vol. 21. No. 4, Winter 1996, p 712.

The fear that the power of markets may overwhelm the community aspects of non-profits is one of the forces that has prompted a movement for a clear articulation of the community benefits that citizens should expect from their non-profit organizations.

With the passage of SB 101 (the nonprofit healthcare merger bill) in the 1997 session of the legislature, New Hampshire has begun to examine the relationship of community benefits (the rewards to the community that accrue with the granting of tax-exempt status to a non-profit organization) and ownership status. When a conversion of an entity from a non-profit to for-profit occurs or when a non-profit transfers more than 25% of its assets to another non-profit certain steps must be taken, including public notice and comment prior to the governing board votes on the transaction.

New Hampshire currently has no law, consensus or policy as to what constitutes community benefits. Non-profit status may no longer be a good proxy for community benefits, and the opportunity costs to the State are considerable. Funds that are lost through the tax exempt status of a non-profit that performs few community benefits could have been redirected to new efforts committed to meeting community needs.

The work needed to identify community benefits requires identification of community activities in health care and proceeds from two perspectives. The first is consideration of an objective record of the activity as indicated within the financial books and accounts of an organization and the second is consideration of how the organization is viewed within its community. Since both the State and communities have vested interests in the process, both should be involved.

Appendix A - Acknowledgements

We wish to express our sincere gratitude to the following citizens, health care professionals, and elected officials who participated in the health care planning and made this report possible.

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Theresa Buteau - Lancaster
Ella Casey - Newport
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Thomas Chrimes - Newport
Gerry Coogan - North Conway
Kevin Cooney - Newport
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Lorraine Demers - No Haverhill
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Alex Easton - Berlin
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Mary Mongan
Judy Moore
Karen Moyer
Joel Neuschatz
Artemis Paras
Ingrid Pelillo
Sandy Pellitier
Ann Peters
Rick Petersen
Jim Piet
Alyson Pitman
Alice Porembski
Phyllis Powell
Alan Robichaud
Eileen Romanowicz
Mary Ruppert
Philip Ryan
Jeanne Sanders
William Schuler
Margaret Seiden
Rick Sherman
Mitch Simon
Larry Singlais
Julie Slagle

Garry Sobelson
Dwight Sowerby
Norman St. Germain
Linda Steir
Peggy Straw
ClydeTerry
Gerald Tobey
John Tobin
Susan Turner
Virginia Vidaver
Norrine Williams
Sue Wnuk
Robert Yager
Susan Young
Karen Young

Town Forums (towns and number of attendees which totaled 635)

Lancaster	90
Claremont	80
Laconia	30
Keene	45
Peterborough	30
Nashua	200
Milford	50
Manchester	45
Portsmouth	45
Salem	20

HMO Executives
Harris Berman
David Jensen
Everett Page
Norman Payton

Department of Insurance
Monica Ciolfi
David Sky
Robert Warren
Colin Mitchell
Deborah O'Laughlin

Department of Education
Joyce Johnson

Attorney General's Office
Michael DeLucia
Walter Maroney

Technical Review and Consultation
Richard Curtis, Executive Director, Institute for Health Policy Solutions, Washington, DC

Randy DeSonia, Director, Health Policy Studies, National Governor's Association, Washington, DC

Robert DiPrete, Director, Health Council, Oregon Health Plan

Elliot Fisher, MD, MPH, Dartmouth Medical School

Susan Friedrich, Executive Director, Community Health Institute, Concord, NH

Alice Hersh (late), CEO, Association for Health Services Research, Washington, DC

Judith Miller Jones, Director, National Health Policy Forum, Washington, DC

Russell Jones, Former Medical Director of Public Health Services

Dick Merritt, Director, Intergovernmental Health Policy Project, National Conference of State Legislators, Washington, DC

Rosemary Orgren, Assistant Professor, Community & Family Medicine, Dartmouth Medical School

Karl Polzer, Senior Research Associate, National Health Policy Forum, Washington, DC

Jeffrey Prottas, Associate Director, Institute for Health Policy, Heller School, Brandeis University, Waltham,MA

Mark Schleshinger, Yale University, New Haven, CT

Bruce Spitz, Independent Consultant, Former Professor of Health Policy, Brandeis University

Jonathan Stewart, Managing Director, Ammonoosuc Family Health Services

Colleagues in Other States

Kansas

Steve McDowell, Executive Director, Rural Health Associates, Lawrence, KS

The People in the Communities of Minneapolis and Wellington, KS

Michigan

Pamela Paul-Shaheen, Executive Director, Comprehensive Community Health Models, Okemos, MI

Representatives form the Michigan Department of Health and Medicaid

Minnesota

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Vermont

Anya Rader, Executive Director, Vermont Program for Quality Health Care, Montpelier, VT

Maggie Moran-Green, Deputy Commissioner, Vermont Department of Health, Burlington, VT

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Vicki Wilson, Health Policy Research and Development, Washington Health Care Authority, Olympia, WA

Appendix B - Health Care Reform in New Hampshire: 1986-1998

1986-1990 Medical Indigence and Access to Care

During this period, the debate on medical indigence and the uninsured began. The New Hampshire Task Force on Indigent Care described New Hampshire as being "on a collision course with the reality of medical indigence" and expressed concern that the ability to cost-shift was disappearing.[64] A few years later a legislative subcommittee called for the State to "measure the problem ... then to have the solution divided between the public and private sectors."[65] In response, an Advisory Council to Governor John Sununu recommended that the Department of Insurance develop a generic, low-cost health insurance plan, and that a survey be conducted to determine the nature, extent, and characteristics of the uninsured population in New Hampshire.[66]

As a result, a 1989 study of the uninsured in New Hampshire was conducted. The report *Health Insurance Coverage in New Hampshire: The Problem and Its Effect on Access to Medical Care,* concluded that:

- two distinct populations were not covered by health insurance in New Hampshire - individuals who worked for firms that did not offer coverage and those who lacked sufficient income to purchase coverage regardless of employment status; and

- the cost of treating the uninsured was being borne by all providers and payers of health care. [67]

The study recommended that the State set up group purchasing arrangements for small employers and develop a subsidized program for those whose incomes were below the federal poverty level but were ineligible for Medicaid. (Single adults or couples without children do not qualify for Medicaid unless they are disabled or elderly.)

The Committee on Access to Health, established soon after the study on the uninsured was released, was charged with overseeing the preliminary steps for improving access within the State.[68] The Committee identified barriers to implementing such a program, including "... a perceived attitude that the uninsured are someone else's responsibility ... and no sense that the State has responsibility to offer such a program to its citizens and to finance it."[69]

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[64] Final Report of the NH Task Force on Indigent Care, June, 1986. "Cost-shifting" or a "cross subsidy" occurs when one patient, e.g., a privately insured patient, is charged more than their costs in order to pay for another patient that was uninsured.

[65] Subcommittee Report on HB 1116, September 30, 1988.

[66] Final Report of the Health Insurance Fund Advisory Council, November, 1988.

[67] Medical Care Development, Inc., *Health Insurance Coverage in New Hampshire: The Problem and its Effect on Access to Medical Care,* Augusta, ME, December, 1989.

[68] The Committee on Access to Health Care, December, 1990.

[69] The Committee on Access to Health Care, December, 1990.

The State implemented several of the Committee's recommendations to improve access to care: Medicaid was expanded for children and pregnant women, comprehensive primary care clinics were established, and health promotion activities were funded. Tabled recommendations included the establishment of a basic health benefit insurance product, the creation of an insurance fund for the uninsured, and the appointment of a permanent body to continue to study the access problem.

1990-1995 Health Reform and Health Planning

During the early 1990s, the State expanded its concern for the uninsured and under Commissioner Harry S. Bird adopted a broad vision of health reform. The *New Hampshire Health Care Reform Plan* was proposed in 1994 with a series of House and Senate bills that devised an infrastructure for reform and created the New Hampshire Health Care Transition Fund for the purpose of transitioning the State to the National Health Care reforms over the next six to seven years.[70]

Legislation was also passed that created small group and individual insurance market reforms (SB 711), mandated community rating (modified only for age)[71], guaranteed issue and renewability, and narrowed restrictions on pre-existing conditions. New Hampshire's reforms in the individual market (prior to Kennedy-Kassenbaum passage) were rated as the most comprehensive in the country.[72]

SB 774 allowed for the expansion of Medicaid eligibility up to 185% of the Federal Poverty Level for children and pregnant women and increased coverage of children in this expanded category up to 19 years of age. New Hampshire was only 1 of 8 states at the 185% level and 1 of 13 states that extended eligibility up to age 19.[73] SB 775 also directed the State to seek Medicaid waivers that would allow adults (who were otherwise not eligible) with incomes below the Federal Poverty Level to participate in Medicaid. Another Medicaid waiver was also sought to provide preventive home and community-based services for the elderly and adults with disabilities through SB 625.

As part of the New Hampshire Health Care Reform Plan, access issues for vulnerable populations were addressed in SB 791. That act called for an expansion of primary care clinics for low income people, continuation of primary care provider recruitment and retention efforts, expansion of services for children with chronic and mental illness, and expansion of substance abuse treatment. The Department of Health and Human Services also planned to request a Medicaid waiver that would garner federal funding for low income

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[70] New Hampshire Health Care Reform Proposal, December, 1993.

[71] Community rating is a method of calculating health insurance premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.

[72] Barents Group, LLC, *State Regulation of the Individual Insurance Market*, Washington, DC, National Institute for Health Care Management, May, 1996.

[73] National Governor's Association, *State Medicaid Coverage of Pregnant Women and Children*, Washington, DC, September, 1996 and Center on Budget and Policy Priorities, *Early Childhood Programs Can Make Medicaid Work For Children*, Washington, DC, October, 1996.

workers (referred to as a Medicaid "buy-in"). Further, it established an Office of Health Planning.

All of the above legislation was predicated on the belief that federal reform would be successful, and that the New Hampshire plan would complement the Federal Health Security Act of 1994 over the next six years. Many of these reform efforts were never implemented because of funding questions and the demise of National Health Care Reform.

In January 1995, Commissioner Terry L. Morton was confirmed. He reviewed the current status of health care planning given the changed environment brought about by the demise of President Clinton's Health Care Reform. With Governor Merrill's support, he introduced HB 60 which became the Department's blueprint for a new approach to health care delivery in New Hampshire. HB 60 restructured the Health Care Transition Fund. Instead of spending $12 million a year for six years, the original intent was modified to create a fund that would exist in perpetuity, protecting the principal while using the interest earnings for health care initiatives. Each year $7 million would be available to fund the State's Medicaid expansion, services to chronically ill children, primary care clinics, provider recruitment and retention efforts, and development of a health planning capacity (the Office of Planning and Research was established in the fall of 1995 and charged with the responsibility for the Health Care Planning Process). HB 60 also created the Community Grant Program - a funded partnership between the State and local communities to support innovative approaches to health care.

During the first half of this decade, the private sector was also assessing health care reform in New Hampshire. The New Hampshire Hospital Association, in collaboration with the Medical Society, the Home Care Association, the Business and Industry Association, and the Commissioner of Health and Human Services developed a vision for health system reform in New Hampshire.[74] Their report included a work plan to carry out the recommendations, one of which was to expand the health reform process into a broad-based, participatory and fact-based project. Other recommendations included insurance coverage for a standard benefit plan for all State residents; continuation and expansion of the health status measures in the DHHS's *Primary Care Access Plan* (currently titled the *Primary Care Access Data*) creation of a collaborative, voluntary organization to produce and disseminate data on health care cost and quality, and transition of the health system to a fully capitated model with universal coverage for all State citizens.

1995 - 1997 Recent Developments in Health Care Reform

While planning for the long term was in process, the State began to take steps necessary to deal with the near future of health care delivery in New Hampshire. Efforts to protect consumers received increased attention. During the 1996 legislative session, a measure was passed prohibiting managed care insurers from having "exclusive arrangements" with providers.[75] The Attorney General's Office, Antitrust Division, examined the development

[74] NH Hospital Association, *Joint Task Force on NH Health Reform*, Concord, NH, 1994.
[75] Chapter 420 - I, 134:2, 1996.

of new delivery system entities such as Integrated Service Networks (ISNs) and Physician Hospital Organizations (PHOs) while the Department of Insurance considered a new formula for solvency requirements for risk-bearing entities.[76] SB 101 (the nonprofit health care merger bill) passed in the 1997 legislative session. This bill codified the role of the Director of Charitable Trusts, in the Attorney General's Office, in dealing with both for-profit acquisitions of charitable healthcare organizations and nonprofit-to-nonprofit consolidations. SB 178 - also from the 1997 legislative session - was the State's first effort at regulating managed care organizations.

During this period, the State had the opportunity to gauge the impact of an earlier reform - SB 711 (which changed the rules for the small group and individual insurance markets). The Department of Insurance commissioned a study on the effects of this legislation on premium rates, the uninsured population and insurance availability. Results released in December, 1997, indicated that the reform legislation was successful and substantially met all of its objectives. It assured "availability" and eliminated "job lock" without evident adverse effects on "affordability".[77]

Present Initiatives for Health Reform

Prior to and during the Health Care Planning Process, the State was pursuing a number of additional health care reform initiatives. These initiatives will be further developed as part of the action steps to implement the strategies laid out in the ***Guidelines for Change***. They include the Medicaid Managed Care Waiver, the Health Care Transition Fund Community Grant Program, the Long Term Care Plan and a related Pilot Demonstration, the development of a solution for the problems in the Non-Group insurance market and the formation of purchaser coalitions (such as the New Hampshire Healthcare Purchasers Roundtable).

Medicaid Managed Care Waiver/Buy-In. Many states have created Medicaid Managed Care programs to improve access to and quality of care for Medicaid enrollees, while at the same time creating a more predictable cost structure for Medicaid than exists under the present fee-for-service program.

The State filed in June 1996 with the Health Care Financing Administration (HCFA) for a waiver of federal Medicaid regulations which would allow the State to implement a managed care program for all participants in Transitional Assistance to Needy Families (TANF) and related groups (the largest number of participants would be women and children). Existing federal Medicaid regulations require states to treat all population groups enrolled in Medicaid alike (women and children, the elderly, blind and disabled).

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[76] National Association of Insurance Commissioners, DRAFT *Health Organization Risk-Based Capital (HORBC)*, June, 1997.

[77] J. Lee, N. McCall, C. Liu, R. Freitas, B. Hart, L. Kirsch and R. Goldstein. *An Investigation into the Effects of the New Hampshire Reform Law, 420-G.* Center for Health Economics Research and IMR Health Economics, LLC. Concord, NH, December, 1997.

The Medicaid Waiver could also provide a financial vehicle to expand coverage to all children in New Hampshire who currently lack access to health insurance benefits (adults would be considered after children).

See section on Subsidizing Private Market Coverage for a detailed discussion of this topic (pages 33-36).

Community Grant Program. The Community Grant Program is funded from interest earned by the Health Care Transition Fund. It is moving into its fourth year of funding community initiatives that encourage creative approaches to address health care needs. The mission of this program is to promote access, improve the quality of health care services, evaluate service delivery and cost models, and improve the purchasing and cost effective utilization of health care services. To date the Department has funded 103 projects worth $10 million. These projects have dealt with a number of areas:

> **Uninsured and the Underserved.** The community grants program has funded projects addressing the needs of the uninsured and the underserved. Approaches vary from underwriting a unique and creative medical service access program for migrant laborers to enabling community health centers to test new ways to serve individuals and families throughout the State who cannot afford adequate health insurance.
>
> **Dental Care.** These projects serve persons in settings as varied as Manchester's downtown neighborhoods and rural Sullivan County. While their primary target group is children, underserved and uninsured persons of all ages are also included. Varied strategies are employed including school-based clinics, hospital-initiated programs, and community outreach.
>
> **Network Support.** Grants have been used to help emerging community-based networks meet an array of medical and social service needs. One example is the development work underway to adapt and produce software that will enable network members, or a set of networks, to develop a "single point of entry" process. Resources have also been provided to enable one of the horizontal networks to develop a common accounting system.

Long Term Care Plan for the Medicaid Population. The State plans to tackle problems in the long term care system on three fronts - the Legislature, the DHHS and the elder care system. Legislation includes extending the moratorium on new nursing home beds to December of 2001, permitting Medicaid funding mid-level care, developing community local points and increasing stakeholder input. On the administrative side, proposals include changing nursing home rate setting standards to reflect the acuity of care and expanding mid-level of care services within the community in order to expand choice. This draft plan lists a

number of pilot projects, such as gradually expanding congregate housing statewide,[78] shared housing[79] and the Cheshire County Pilot Demonstration described below.

Dual-Eligibles Cheshire County Pilot Demonstration. The term Dual Eligibles refers to certain low-income elders and the low-income disabled who are eligible for both Medicare and Medicaid (the State pays Medicare premiums for low income elders who cannot afford them through the Medicaid Program). On May 26, 1998 the DHHS submitted the Cheshire County Pilot to HCFA. *Building Tomorrow's Choices* is a Medicaid 1115 waiver request, targeting approximately 1,200 in Cheshire County. The ultimate goal is to integrate the full range of existing community-based services and delivery systems, both acute and long term care, under a capitated financing structure. The Cheshire County demonstration will pre-test all aspects of the planned New Hampshire model for a fully integrated service delivery system for the entire dual eligible population. The new system will be person-centered and will focus on wellness and the positive capacities of each person served regardless of the type or degree of disability the person carries. Services will be delivered locally by integrated service networks which include all provider types necessary to insure the availability of all services currently provided under Medicare and Medicaid and any new services which evolve.

Risk Adjustment for the Non-group Market. The cost of health insurance for many individuals in the non-group market in New Hampshire has been escalating sharply. This market has such a small number of covered lives (the vast majority of the insured population participate in group insurance plans), hence, little opportunity to spread risk among participants and keep premiums affordable. As premiums increased, healthier consumers dropped coverage, which led to a further increase in rates for the persons remaining who were generally less healthy (escalation of premiums while lower risk consumers drop coverage is referred to as a "death spiral" in the insurance business). This was particularly true for Blue Cross and Blue Shield of New Hampshire which had the largest number of covered lives, the higher risk enrollees, and the highest premium increases. The result - Blue Cross and Blue Shield withdrew from the non-group market effective January 1, 1998.

As a short term measure, the New Hampshire Insurance Department is attempting to stabilize the non-group market by implementing a risk adjustment and subsidy mechanism. All health insurance carriers in all markets will be assessed an amount that is based on their number of covered lives. The fund generated in this manner will be used to offset catastrophic expenses for high cost enrollees among carriers that currently offer health insurance policies in the non-group market. This strategy represents an effort to stabilize the non-group market by spreading the risk of high-cost enrollees beyond this small market.

[78] NH currently has a Congregate Housing Services Program (CHSP) which delivers supportive services (in low-rent housing with a central dining facility) that enable frail elderly and non-elderly incapacitated adults to maintain their independence and avoid institutionalization.

[79] Shared housing includes "adult family care services" which consist of care and assistance provided in an adult family care home to an elderly or disabled individual who, by reason of physical or mental disability, would be in an institution if not for these services. This model is based on foster care for children.

New Hampshire Healthcare Purchasers Roundtable. The Department of Health and Human Services is an active participant in the New Hampshire Healthcare Purchasers Roundtable. The Roundtable is a partnership of public and private health care purchasers working together to ensure health care that is accessible, affordable and of high quality. The Roundtable presently represents over 3000,000 covered lives. Some of the objectives of the Roundtable include:

- responding to growing health care market consolidation by bringing public and private purchasers together around an active, consumer-oriented agenda;
- promoting value-based purchasing by building into the purchasing process criteria that address quality as well as cost;
- working collaboratively with providers and health plans to develop common standards and mechanisms for data collection and performance evaluation;
- working collaboratively with providers and health plans to promote continuous improved performance and coordinated action to address identified community needs; and
- educating purchasers and consumers of health care services.

Appendix C -Index to Recommendations

A. Promoting Access To Health Coverage While Managing Costs

Recommendation 1. The Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General, together with market participants, should jointly monitor and respond to market behavior. (Page 26)

Recommendation 2. Monitor the uninsured and underinsured to track the effectiveness of the changing market in addressing their needs. (Page 27)

Recommendation 3. Consider establishing a standardized set of benefit packages for the health insurance market. (Page 27)

Recommendation 4. Consider establishing a risk adjustment system for the health insurance market. (Page 28)

Recommendation 5. Establish a statewide health insurance purchasing alliance for small employers and for individuals. (Page 30)

Recommendation 6. Provide a subsidy for the purchase of private insurance coverage for those who are uninsured because they cannot afford it. (Page 34)

Recommendation 7. Determine the scope of "safety net" services that should be available, the necessary level and sources of funding to maintain these services, and who should provide the services. (Page 37)

Recommendation 8. Support and promote systems that coordinate health-related non-medical services with medical care to improve outcomes. (Page 39)

Recommendation 9. Revise the role of Certificate of Need to keep pace with the rapidly changing health care market. (Page 39)

Recommendation 10. Work with communities, market and provider representatives to establish both minimum standards of adequacy for the delivery system and a process and incentives for encouraging providers to practice within medical shortage areas or areas that do not meet minimum standards of adequacy. (Page 41)

B. Protecting And Empowering Consumers

Recommendation 11. Establish an independent mediator, with the authority to make recommendations, for disputes arising among consumers, providers, health insurers and managed care organizations. (Page 44)

Recommendation 12. Create an independent consumer hotline for complaints regarding health insurance coverage. (Page 45)

Recommendation 13. Promote and participate in an organization which would develop innovative quality monitoring and improvement activities. (Page 47)

Recommendation 14. Develop a coordinated monitoring policy for all health care services for which there is current State Legislative or regulatory authority. (Page 48)

Recommendation 15. Develop the capacity to provide data that allows citizens to review the health status of communities and the statewide population; to understand the performance of State and market functions; and to understand the status of community concerns. (Page 49)

Recommendation 16. Promote the private development of information that helps improve the health status of New Hampshire citizens and the operation of the health care system. (Page 50)

Recommendation 17. Establish licensure for health care organizations that bear financial risk based on a formula that adjusts capital and reserve requirements to the number of covered lives served by an organization, its structure, and the percent of risk that the organization will assume. (Page 52)

Recommendation 18. Develop guidelines governing the transfer of financial risk from one entity to another. (Page 53)

Recommendation 19. Establish the capacity to track the number of self-insured plans, require such plans to disclose to their enrollees that they are self-insured, and provide support and guidance to individuals insured under such plans. (Page 54)

C. Re-Defining Public Health

Recommendation 20. Collaborate with the Turning Point Steering Committee to reassess the functions of public health. (Page 57)

Recommendation 21. Determine whether current baseline monitoring efforts are adequate or should be expanded to monitor health risks and outbreaks. (Page 58)

Recommendation 22. Implement improved coordination of health promotion and wellness activities across government agencies, managed care and other organizations. (page 59)

Recommendation 23. Determine the level of support which the State and private entities (such as managed care organizations) ought to provide to public and private health care provider training programs. (Page 60)

Recommendation 24. Determine the critical areas for public health and public research and establish criteria for public and private funding. (Page 61)

D. Partnering With Communities

Recommendation 25. Maintain and protect the Health Care Transition Fund to support innovations in the delivery of health and social services. (Page 67)

Recommendation 26. Retain the District Councils as a permanent part of health planning and policy development. (Page 70)

Recommendation 27. Develop operational standards for community benefits, with representatives from communities, non-profit providers, and representatives from the Department of Insurance and the Office of the Attorney General, that reflect community values. (Page 71)

HEALTH CARE DELIVERY AND FINANCING TERMS

A

access
An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage.

accreditation
A process whereby a program of study or an institution is recognized by an external body as meeting certain predetermined standards. For facilities, accreditation standards are usually defined in terms of physical plant, governing body, administration, and medical and other staff. Accreditation is often carried out by organizations created for the purpose of assuring the public of the quality of the accredited institution or program. The State or Federal governments can recognize accreditation in lieu of, or as the basis for licensure or other mandatory approvals. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent or may be given for a specified period of time.

Activities of Daily Living (ADL)
An index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating, and moving from one place to another.

acute care
Medical treatment rendered to individuals whose illnesses or health problems are of a short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.

acute disease
A disease which is characterized by a single episode of a relatively short duration from which the patient returns to his/her normal or previous state of level of activity. While acute diseases are frequently distinguished from chronic diseases, there is no standard definition or distinction. It is worth noting that an acute episode of a chronic disease (for example, an episode of diabetic coma in a patient with diabetes) is often treated as an acute disease.

adjusted average per capita cost (AAPCC)
The basis for HMO or CMP reimbursement under Medicare-risk contracts. The average monthly amount received per enrollee is currently calculated as 95 percent of the average costs to deliver medical care in the fee-for-service sector.

adverse selection
A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average health status apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.

affiliation
An agreement (usually formal) between two or more otherwise independent entities or individuals which defines how they will relate to each other. Affiliation agreements between hospitals may specify procedures for referring or transferring patients from one facility to another, joint faculty and/or medical staff appointments, teaching relationships, sharing of records or services, or provision of consultation between programs.

Agency for Health Care Policy and Research (AHCPR)
One of the newest agencies of the U.S. Public Health Service, the AHCPR was created in 1989. The Agency's primary goal is to enhance the quality, appropriateness, and effectiveness of health care services by conducting and sponsoring credible and timely research. It is the federal government's focal point for health services research, the efforts of which are built upon the work of AHCPR's predecessor, the National Center for Health Services Research and Health Care Technology Assessment.

Aid to Families with Dependent Children (AFDC)
A state-based federal cash assistance program for low-income families. In all states, AFDC recipiency may be used to establish Medicaid eligibility.

all patient diagnosis related groups (APDRG)
An enhancement of the original DRGs, designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV-related conditions and other special cases.

all-payer system
A system in which prices for health services and payment methods are the same, regardless of who is paying. For instance, in an all-payer system, federal or state government, a private insurer, a self-insured employer plan, an individual, or any other payer could pay the same rates. The uniform fee bars health care providers from shifting costs from one payer to another. See cost shifting.

allied health personnel
Specially trained and licensed (when necessary) health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses. The term has no constant or agreed-upon detailed meaning; sometimes used synonymously with paramedical personnel, sometimes meaning all health workers who perform tasks which must otherwise be performed by a physician, and at other times referring to health workers who do not usually engage in independent practice.

allowable costs
Items or elements of an institution's costs which are reimbursable under a payment formula. Both Medicare and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury accommodations, costs which are not reasonable expenditures, which are unnecessary, for the efficient delivery of health services to persons covered under the program in question, or depreciation on a capital expenditure which was disapproved by a health planning agency.

ambulatory care
All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay. See also ambulatory setting and outpatient.

ambulatory setting
A type of institutional organized health setting in which health services are provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).

ancillary services
Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, that are provided in conjunction with medical or hospital care.

antitrust
A legal term encompassing a variety of efforts on the part of government to assure that sellers do not conspire to restrain trade or fix prices for their goods or services in the market.

any willing provider laws
Laws that require managed care plans to contract with all health care providers that meet their terms and conditions.

appropriateness
Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.

Area Health Education Center (AHEC)
An organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use, and efficiency of health care personnel in specific medically underserved areas. An AHEC's objectives are to educate and train the health personnel specifically needed by the underserved areas and to decentralize health workforce education, thereby increasing supply and linking the health and educational institutions in scarcity areas.

assignment
A process in which a Medicare beneficiary agrees to have Medicare's share of the cost of a service paid directly ("assigned") to a doctor or other provider, and the provider agrees to accept the Medicare approved charge as payment in full. Medicare pays 80 percent of the cost and the beneficiary 20 percent, for most services. See participating physician.

avoidable hospital condition
Medical diagnosis for which hospitalization could have been avoided if ambulatory care had been provided in a timely and efficient manner.

B

bad debts
Income lost to a provider because of failure of patients to pay amounts owed. Bad debts may sometimes be recovered by increasing charges to paying patients. Some cost-based reimbursement programs reimburse certain bad debts. The impact of the loss of revenue from bad debts may be partially offset for proprietary institutions by the fact that income tax is not payable on income not received.

balance billing
In Medicare and private fee-for-service health insurance, the practice of billing patients for charges that exceed the amount that the health plan will pay. Under Medicare, the excess amount cannot be more than 15 percent above the approved charge. See approved charge and participating physician.

beneficiary
An individual who receives benefits from or is covered by an insurance policy or other health care financing program.

Blue Cross plan
A nonprofit, tax-exempt insurance plan providing coverage for hospital care and related services. (The individual plans should be distinguished from their national association, the Blue Cross Association.) Historically, the plans were largely the creation of the hospital industry and designed to provide hospitals with a stable source of revenue. A Blue Cross plan should be a nonprofit community service organization with a governing body whose membership includes a majority of public representatives.

Blue Shield plan
A nonprofit, tax-exempt insurance plan which provides coverage for physicians' services. Blue Shield coverage is sometimes sold in conjunction with Blue Cross coverage, although this is not always the case.

board certified
Status granted a medical specialist who completes a required course of training and experience (residency) and passes an examination in his/her specialty. Individuals who have met all requirements except examination are referred to as "board eligible."

Boren Amendment
Part of the Medicaid law, known by the name of its principal Congressional sponsor. It provides that state payment for hospitals and nursing facilities must be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities to provide care and services meeting state and federal standards.

C

capital
Fixed or durable non-labor inputs or factors used in the production of goods and services, the value of such factors, or the money specifically allocated for their acquisition or development. Capital costs include, for example, the buildings, beds, and equipment used in the provision of hospital services. Capital assets are usually thought of as permanent and durable as distinguished from consumables such as supplies.

capital expenditure review
A review of proposed capital expenditures of hospitals and/or other health facilities to determine the need for, and appropriateness of, the proposed expenditures. The review is done by a designated regulatory agency and has a sanction attached which prevents or discourages unneeded expenditures.

capitation
A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant" from the Federal government for each student enrolled.

carrier
A private organization, usually an insurance company, that finances health care.

carve out
Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.

case management
The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.

case-mix
A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

catastrophic health insurance
Health insurance which provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

catchment area
A geographic area defined and served by a health program or institution such as a hospital or community mental health center which is delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. By definition, all residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria.

categorically needy
Persons whose Medicaid eligibility is based on their family, age or disability status. Persons not falling into these categories cannot qualify, no matter how low their income. The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all states and those that may be covered at a state's option. The scope of covered services that states provide to the categorically needy is much broader than the minimum scope of services for the other, optional groups receiving Medicaid benefits. See medically needy.

Centers for Disease Control and Prevention (CDC)
The Centers for Disease Control and Prevention, based in Atlanta, Georgia, charged with protecting the nations' public health by providing direction in the prevention and control of communicable and other diseases and responding to public health emergencies. Within the U.S. Public Health Service, CDC is the agency that led efforts to prevent such diseases as malaria, polio, smallpox, toxic shock syndrome, Legionnaire's disease and, more recently, acquired immunodeficiency syndrome (AIDS), and tuberculosis. CDC's responsibilities evolve as the agency addresses contemporary threats to health, such as injury, environmental and occupational hazards, behavioral risks, and chronic diseases.

Certificate of Need (CON)
A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

certification
The process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution, or educational program as meeting predetermined standards. One so recognized is said to be "certified." It is essentially synonymous with accreditation, except that certification is usually applied to individuals, and accreditation to institutions. Certification programs are generally nongovernmental and do not exclude the uncertified from practice as do licensure programs.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)
A Department of Defense program supporting private sector care for military dependents.

charity care
Generally refers to physician and hospital services provided to persons who are unable to pay for the cost of services, especially those who are low-income, uninsured and underinsured. A high proportion of the costs of charity care is derived from services for children and pregnant women (e.g., neonatal intensive care).

chronic care
Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.

chronic disease
A disease which has one or more of the following characteristics: is permanent, leaves residual disability; is caused by nonreversible pathological alternation, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.

clinic
A facility, or part of one, devoted to diagnosis and treatment of outpatients. "Clinic" is irregularly defined. It may either include or exclude physicians' offices; may be limited to describing facilities which serve poor or public patients; and may be limited to facilities in which graduate or undergraduate medical education is done.

coinsurance
A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume

a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.

community-based care
The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

community health center
An ambulatory health care program (defined under Section 330 of the Public Health Service Act) usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs; sometimes known as "neighborhood health center." Community health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all health care services needed by its patient population.

Community Health Management Information Systems (CHMIS)
An automated communication network supporting the transfer of clinical and financial information, currently under development with the support of the John A. Hartford Foundation.

Community Mental Health Center (CMHC)
An entity which provides comprehensive mental health services (principally ambulatory), primarily to individuals residing or employed in a defined catchment area.

community rating
A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.

community rating by class (class rating)
For federally qualified HMOs, the Community - Rating by Class (CRC)—adjustment of community-rated premiums on the basis of such factors as age, sex, family size, marital status, and industry classification. These health plan premiums reflect the experience of all enrollees of a given class within a specific geographic area, rather than the experience of any one employer group.

Competitive Medical Plan (CMP)
A state-licensed entity, other than a federally qualified HMO, that signs a Medicare Risk Contract and agrees to assume financial risk for providing care to Medicare eligible on a prospective, prepaid basis.

continuing medical education (CME)
Formal education obtained by a health professional after completing his/her degree and full-time postgraduate training. For physicians, some States require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.

coordination of benefits (COB)
Procedures used by insurers to avoid duplicate payment for losses insured under more than one insurance policy. A coordination of benefits, or "nonduplication," clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered. Standard rules determine which of two or more plans, each having COB provisions, pays its benefits in full and which becomes the supplementary payer on a claim.

copayment
A form of cost sharing in which a fixed amount of money is paid by the insured for each health care service provided.

cost-benefit analysis
An analytic method in which a program's cost is compared to the program's benefits for a period of time, expressed in dollars, as an aid in determining the best investment of resources. For example, the cost of establishing an immunization service might be compared with the total cost of medical care and lost productivity which will be eliminated as a result of more persons being immunized. Cost-benefit analysis can also be applied to specific medical tests and treatments.

cost center
An accounting device whereby all related costs attributable to some "financial center" within an institution, such as a department or program are segregated for accounting or reimbursement purposes.

cost sharing
Any provision of a health insurance policy that requires the insured individual to pay some portion of medical expenses. The general term includes

deductibles, copayments, and coinsurance.

cost-shifting
The condition that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically results from providing health care to the medically indigent or the Medicare patients.

covered services
Health care services covered by an insurance plan.

credentialing
The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used.

Current Population Survey (CPS)
A national survey conducted annually by the U.S. Department of Commerce, Bureau of the Census, the CPS gathers information on the noninstitutionalized population of the United States. The CPS is the most commonly reported source for the number of persons without health insurance and other information about this population.

Current Procedural Terminology, fourth edition (CPT-4)
A manual that assigns five digit codes to medical services and procedures to standardize claims processing and data analysis.

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customary charge
One of the factors determining a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period.

customary, prevailing, and reasonable (CPR)
Current method of paying physicians under Medicare. Payment for a service is limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charge for that service in the community. Similar to the Usual, Customary, and Reasonable system used by private insurers.

D

deductible
The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed-dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g., $100 per calendar year, benefit period, or spell of illness.

defined benefit
Funding mechanisms for pension plans that can also be applied to health benefits. Typical pension approaches include: (1) pegging benefits to a percentage of an employee's average compensation over his/her entire service or over a particular number of years; (2) calculation of a flat monthly payment; (3) setting benefits based upon a definite amount for each year of service, either as a percentage of compensation for each year of service or as a flat dollar amount for each year of service.

defined contribution
Funding mechanism for pension plans that can also be applied to health benefits based on a specific dollar contribution, without defining the services to be provided.

deinstitutionalization
Policy which calls for the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.

developmental disability (DD)
A severe, chronic disability which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living,

economic self-sufficiency; and reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care treatments of services which are of lifelong or extended duration and are individually planned and coordinated.

Diagnosis Related Groups (DRGs)
Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system.

disability
Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person's usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.

discharge
The release of a patient from a provider's care, usually referring to the date at which a patient checks out of a hospital.

disease
May be defined as a failure of the adaptive mechanisms of an organism to counteract adequately, normally, or appropriately to stimuli and stresses to which it is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and drug dependence are presently seen by some as diseases, when they were previously considered to be moral or legal problems.

durable medical equipment
Prescribed medical equipment (e.g., wheelchair, respirator) that can be used for an extended period of time.

E

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.

electronic claim
A digital representation of a medical bill generated by a provider or by the provider's billing agent for submission using telecommunications to a health insurance payer.

electronic data interchange (EDI)
The mutual exchange of routine information between business using standardized, machine-readable formats.

emergency medical services (EMS)
Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.

Employee Retirement Income Security Act (ERISA)
A Federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from State insurance laws.

encounter
A contact between an individual and the health care system for a health care service or set of services related to one or more medical conditions.

epidemic
A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, e.g., an epidemic of violence.

epidemiology
The study of the patterns of determinants and antecedents of disease in human populations. Epidemiology utilizes biology, clinical medicine, and statistics in an effort to understand the etiology (causes) of illness and/or disease. The ultimate goal of the epidemiologist is not merely to identify underlying causes of a disease but to apply findings to disease prevention and health promotion.

exclusive provider arrangement (EPA)
An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).

expenditure target (ET)
A mechanism to adjust fee updates (or the fees themselves) based on how actual expenditures in an area compare to a target for those expenditures.

experience rating
A method of adjusting health plan premiums based on the historical utilization data and distinguishing characteristics of a specific subscriber group.

F

family practice
A form of specialty practice in which physicians provide continuing comprehensive primary care within the context of the family unit.

favorable selection
A tendency for utilization of health services in a population group to be lower than expected or estimated.

Federal Poverty Level (FPL)
Poverty guidelines are established by the Department of Health and Human Services and are issued each year in the *Federal Register*. They are used to determine individuals' and families' eligibility for various Federal and non-Federal programs. They are the same in the 48 contiguous States and the District of Columbia and are higher in Alaska and Hawaii.

Federally Qualified Health Center (FQHC)
A federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Federal legislation creating the FQHC category was enacted in 1989.

fee-for-service
Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of U.S. physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.

fee schedule
An exhaustive list of physician services in which each entry is associated with a specific monetary amount that represents the approved payment level for a given insurance plan.

fiduciary
Relating to, or founded upon, a trust or confidence. A fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person's or organization's interests in matters which affect the other person or organization. A physician has such a relation with his/her patient, and a hospital trustee has one with a hospital.

G

gatekeeper
The primary care practitioner in managed care organizations who determines whether the presenting patient needs to see a specialist or requires other non-routine services. The goal is to guide the patient to appropriate services while avoiding unnecessary and costly referrals to specialists.

general practice
A form of practice in which physicians without specialty training provide a wide range of primary health care services to patients.

global budgeting
A method of hospital cost containment in which participating hospitals must share a prospectively set budget. Method for allocating funds among hospitals may vary but the key is that the participating hospitals agree to an aggregate cap on revenues that they will receive each year. Global budgeting may also be mandated under a universal health insurance system.

global fee
A total charge for a specific set of services, such as obstetrical services that encompass prenatal, delivery and post-natal care.

Graduate Medical Education (GME)
Medical education after receipt of the Doctor of Medicine (MD) or equivalent degree, including the education received as an intern, resident (which involves training in a specialty) or fellow, as well as continuing medical education. HCFA partly finances GME through Medicare direct and indirect payments.

group practice
A formal association of three or more physicians or other health professionals providing health services. Income from the practice is pooled and redistributed to the members of the group according to some prearranged plan (often, but not necessarily, through partnership). Groups vary a great deal in size, composition, and financial arrangements.

guaranteed issue
Requirement that health plans offer coverage to all businesses during some period each year.

H

handicapped
As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.

health
The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms or morbidity and mortality.

Health Care Financing Administration (HCFA)
The government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs.

health education
Any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conducive to health.

health facilities
Collectively, all physical plants used in the provision of health services; usually limited to facilities which were built for the purpose of providing health care, such as hospitals and nursing homes. They do not include an office building which includes a physician's office. Health facility classifications include: hospitals (both general and specialty), long-term care facilities, kidney dialysis treatment centers, and ambulatory surgical facilities.

health insurance
Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Sometimes called the Kennedy-Kassebaum bill, this legislation sets a precedent for Federal involvement in insurance regulation. It sets minimum standards for regulation of the small group insurance market and for a set group in the individual insurance market in the area of portability and availability of health insurance.

health insurance purchasing cooperatives (HIPCs)
Public or private organizations which secure health insurance coverage for the workers of all member employers. The goal of these organizations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans and providers, to reduce the administrative costs of buying, selling and managing insurance policies. Private cooperatives are usually voluntary associations of employers in a similar geographic region who band together to purchase insurance for their employees. Public cooperatives are established by state governments to purchase insurance for public employees, Medicaid beneficiaries, and other designated populations.

health maintenance organization (HMO)
An entity with four essential attributes: (1) an organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons; and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

Health Manpower Shortage Area (HMSA)
An area or group which the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HMSAs can include: (1) an urban or rural geographic area, (2) a population group for which access barriers can be demonstrated to prevent members of the group

from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.

health personnel
Collectively, all persons working in the provision of health services, whether as individual practitioners or employees of health institutions and programs, whether or not professionally trained, and whether or not subject to public regulation. Facilities and health personnel are the principal health resources used in producing health services.

health plan
1) An organization that provides a defined set of benefits; this term usually refers to an HMO-like entity, as opposed to an indemnity insurer.

Health Plan Employer Data and Information Set (HEDIS)
A core set of performance measures designed by the National Committee for Quality Assurance to enable plans and employers to accurately trend health plan performance in a comparative manner.

health planning
Planning concerned with improving health, whether undertaken comprehensively for a whole community or for a particular population, type of health service, institution, or health program. The components of health planning include: data assembly and analysis, goal determination, action recommendation, and implementation strategy.

health policy
An insurance contract consisting of a defined set of benefits. See health insurance.

health promotion
Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.

Health Resources and Services Administration (HRSA)
One of the eight agencies of the U.S. Public Health Service, HRSA has responsibility for addressing resource issues relating to access, equity and quality of health care, particularly to the disadvantaged and underserved. HRSA provides leadership to assure the support and delivery of primary health care services, particularly in underserved areas, and the development of qualified primary care health professionals and facilities to meet the health needs of the nation. HRSA focuses on support of states and communities in their efforts to plan, organize, and deliver primary health care, as well as strengthen the overall public health system.

health service area
Geographic area designated on the basis of such factors as geography, political boundaries, population, and health resources, for the effective planning and development of health services.

health status
The state of health of a specified individual, group, or population. It may be measured by obtaining proxies such as people's subjective assessments of their health; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by using the incidence or prevalence of major diseases (communicable, chronic, or nutritional). Conceptually, health status is the proper outcome measure for the effectiveness of a specific population's medical care system, although attempts to relate effects of available medical care to variations in health status have proved difficult.

Health Systems Agency (HSA)
A health planning agency created under the National Health Planning and Resources Development Act of 1974. HSAs were usually nonprofit private organizations and served defined health service areas as designated by the States.

Hill-Burton
Coined from the names of the principal sponsors of the Public Law 79-725 (the Hospital Survey and Construction Act of 1946); this program provided Federal support for the construction and modernization of hospitals and other health facilities. Hospitals that have received Hill-Burton funds incur an obligation to provide a certain amount of charity care.

hold-harmless
A contractual requirement prohibiting a provider from seeking payment from an enrollee for services rendered prior to a health plan insolvency.

holism
Refers to the integration of mind, body, and spirit of a person and emphasizes the importance of perceiving the individual (regarding physical symptoms) in a "whole" sense. Holism teaches that the health care system must extend its focus beyond solely the physical aspects of disease and particular organ in question, to concern itself with the whole person and the interrelationships between the emotional, social, spiritual, as well as physical implications of disease and health.

home health care
Health services rendered in the home to the aged, disabled, sick, or convalescent individuals who do not need institutional care. The services may be

provided by a visiting nurse association (VNA) home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive. The most common types of home health care are the following—nursing services; speech, physical, occupational and rehabilitation therapy; homemaker services; and social services.

horizontal integration
Merging of two or more firms at the same level of production in some formal, legal relationship. See vertical integration

hospice
A program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Originally a medieval name for a way station for crusaders where they could be replenished, refreshed, and cared for, hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.

hospital
An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat), and by type of ownership or control (Federal, State, or local government; for-profit and nonprofit). The hospital system is dominated by the short-term, general, nonprofit community hospital, often called a voluntary hospital.

I

incidence
In epidemiology, the number of cases of disease, infection, or some other event having their onset during a prescribed period of time in relation to the unit of population in which they occur. Incidence measures morbidity or other events as they happen over a period of time. Examples include the number of accidents occurring in a manufacturing plant during a year in relation to the number of employees in the plant, or the number of cases of mumps occurring in a school during a month in relation to the number of pupils enrolled in the school. It usually refers only to the number of new cases, particularly of chronic diseases.

incurred but not reported (IBNR)
Claims that have not been reported to the insurer as of some specific date for services that have been provided. The estimated value of these claims is a component of an insurance company's current liabilities.

indemnity
Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for covered services.

independent practice association (IPA)
An organized form of prepaid medical practice in which participating physicians remain in their independent office settings, seeing both enrollees of the IPA and private-pay patients. Participating physicians may be reimbursed by the IPA on a fee-for-service basis or a capitation basis.

indigent care
Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for Federal or State programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.

inpatient
A person who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his/her room and board) for the purpose of receiving diagnostic treatment or other health services.

institutional health services
Health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient institutions. The term may also refer to services delivered on an outpatient basis by departments or other organizational units of, or sponsored by, such institutions.

instrumental activities of daily living (IADL)
An index or scale which measures a patient's degree of independence in aspects of cognitive and social functioning including shopping, cooking, doing housework, managing money, and using the telephone.

integrated services network (ISN)
A network of organizations usually including hospitals and physician groups, that provides or arranges to provide a coordinated continuum of

services to a defined population and is held both clinically and fiscally accountable for the outcomes of the populations served.

intermediate care facility (ICF)
An institution which is licensed under State law to provide on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally retarded or people with related conditions are also included in the definition. The distinction between "health--related care and services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different regulations and coverage requirements than institutions which do not provide health-related care and services.

international medical graduate (IMG)
A physician who graduated from a medical school outside of the United States, usually Canada. U.S. citizens who go to medical school abroad are classified as international medical graduates just as are foreign-born persons who are not trained in a medical school in this country. U.S. citizens represent only a small portion of the IMG group.

intervention strategy
A generic term used in public health to describe a program or policy designed to have an impact on an illness or disease. Hence a mandatory seat belt law is an intervention designed to reduce automobile-related fatalities.

J

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
A national private, nonprofit organization whose purpose is to encourage the attainment of uniformly high standards of institutional medical care. Establishes guidelines for the operation of hospitals and other health facilities and conducts survey and accreditation programs.

K

Katie Beckett children
Disabled children who qualify for home care coverage under a special provision of Medicaid, named after a girl who remained institutionalized solely to continue Medicaid coverage.

L

license/licensure
A permission granted to an individual or organization by a competent authority, usually public, to engage lawfully in a practice, occupation, or activity. Licensure is the process by which the license is granted. It is usually granted on the basis of examination and/or proof of education rather than on measures of performance. A license is usually permanent but may be conditioned on annual payment of a fee, proof of continuing education, or proof of competence.

limited service hospital
A hospital, often located in rural areas, that provides a limited set of medical and surgical services.

long-term care
A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

M

magnetic resonance imaging (MRI)
This relatively new form of diagnostic radiology is a method of imaging body tissues that uses the response or resonance of the nuclei of the atoms of one of the bodily elements, typically hydrogen or phosphorus, to externally applied magnetic fields.

malpractice
Professional misconduct or failure to apply ordinary skill in the performance of a professional act. A practitioner is liable for damages or injuries caused by malpractice. For some professions like medicine, malpractice insurance can cover the costs of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit. To prove malpractice requires that a patient demonstrate some injury and that the injury be caused by negligence.

managed care
The body of clinical, financial and organizational activities designed to ensure the provision of appropriate health care services in a cost-efficient

manner. Managed care techniques are most often practiced by organizations and professionals which assume risk for a defined population (e.g., health maintenance organizations).

management services organization
The management services organization provides administrative and practice management services to physicians. An MSO may typically be owned by a hospital, hospitals, or investors. Large group practices may also establish MSOs to sell management services to other physician groups.

maximum allowable actual charge (MAAC)
A limitation on billed charges for Medicare services provided by nonparticipating physicians. For physicians with charges exceeding 115 percent of the prevailing charge for nonparticipating physicians, MAACs limit increases in actual charges to 1 percent a year. For physicians whose charges are less than 115 percent of the prevailing, MAACs limit actual charge increases so they may not exceed 115 percent.

McCarran-Ferguson Act
A 1945 Act of Congress exempting insurance businesses from federal commerce laws and delegating regulatory authority to the states.

Medicaid (Title XIX)
A Federally aided, State-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

medical audit
Detailed retrospective review and evaluation of selected medical records by qualified professional staff. Medical audits are used in some hospitals, group practices, and occasionally in private, independent practices for evaluating professional performance by comparing it with accepted criteria, standards, and current professional judgement. A medical audit is usually concerned with the care of a given illness and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it.

medically indigent
Persons who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.

medical management information system (MMIS)
A data system that allows payers and purchasers to track health care expenditure and utilization patterns.

medical savings account (MSA)
An account in which individuals can accumulate contributions to pay for medical care or insurance. Some states give tax-preferred status to MSA contributions, but such contributions are still subject to federal income taxation. MSAs differ from Medical reimbursement accounts, sometimes called flexible benefits or Section 115 accounts, in that they need not be associated with an employer. MSAs are not currently recognized in federal statute.

medically needy
Persons who are categorically eligible for Medicaid and whose income, less accumulated medical bills, is below state income limits for the Medicaid program. See spend down.

medically underserved population
A population group experiencing a shortage of personal health services. A medically underserved population may or may not reside in a particular medically underserved area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for Federal assistance (e.g., the National Health Service Corps).

Medicare (Title XVIII)
A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Medicare approved charge
The amount Medicare approves for payment to a physician. Typically, Medicare pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. Physicians may bill beneficiaries for an additional amount (the balance) not to exceed 15 percent of the Medicare approved charge. See balance billing.

Medicare risk contract
An agreement by an HMO or competitive medical plan to accept a fixed dollar reimbursement per Medicare enrollee, derived from costs in the fee-for--

service sector, for delivery of a full range of prepaid health services.

medigap policy
A private health insurance policy offered to Medicare beneficiaries to cover expenses not paid by Medicare. Medigap policies are strictly regulated by federal rules. Also known as Medicare supplemental insurance.

mental health services
Comprehensive mental health services, as defined under some state laws and federal statutes, include: inpatient care, outpatient care, day care, and other partial hospitalization and emergency services; specialized services for the mental health of children; specialized services for the mental health of the elderly; consultation and education services; assistance to courts and other public agencies in screening catchment area residents; follow-up care for catchment area residents discharged from mental health facilities or who would require inpatient care without such halfway house services; and specialized programs for the prevention, treatment and rehabilitation of alcohol and drug abusers.

mental illness
All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought, and definitions. It includes a wide range of types and severities.

morbidity
The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

mortality
Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex, or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).

multiple employer trust (MET)
Arrangement through which two or more employers can provide benefits, including health coverage, for their employees. Arrangements formed by associations of similar employers were exempt from most state regulations. Redefined as a MEWA by the Multiple Employer Welfare Arrangement Act of 1982.

multiple employer welfare arrangement (MEWA)
As defined in 1983 Erlenborn ERISA Amendment, an employee welfare benefit plan or any other arrangement providing any of the benefits of an employee welfare benefit plan to the employees of two or more employers. MEWAs that do not meet the ERISA definition of employee benefit plan and are not certified by the U.S. Department of Labor may be regulated by states. MEWAs that are fully insured and certified must only meet broad state insurance laws regulating reserves.

N

National Committee for Quality Assurance (NCQA)
A national organization founded in 1979 composed of 14 directors representing consumers, purchasers, and providers of managed health care. It accredits quality assurance programs in prepaid managed health care organizations develops and coordinates programs for assessing the quality of care and service in the managed care industry.

National Health Service Corps (NHSC)
A program administered by the U.S. Public Health Service that places physicians and other providers in health professions shortage areas by providing scholarship and loan repayment incentives. Since 1970, the Corps members have worked in community health centers, migrant centers, Indian health facilities and in other sites targeting underserved populations.

network
An affiliation of providers through formal and informal contracts and agreements. Networks may contract externally to obtain administrative and financial services.

nurse
An individual trained to care for the sick, aged, or injured. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing. There are many different types, specialties, and grades of nurses.

nurse practitioner
A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term

care facilities, and other health care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his/her or her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for-service reimbursement for their services.

nursing home
Includes a wide range of institutions which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems which range from minimal to very serious. The term includes free-standing institutions, or identifiable components of other health facilities which provide nursing care and related services, personal care, and residential care. Nursing homes include skilled nursing facilities and extended care facilities but not boarding homes.

O

occupancy rate
A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital's beds occupied and may be institution-wide or specific for one department or service.

occupational health services
Health services concerned with the physical, mental, and social well-being of an individual in relation to his/her working environment and with the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the U.S., the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

open enrollment
A method for assuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

organized delivery system (ODS)
See integrated services network (ISN).

outcomes research
Research on measures of changes in patient outcomes, that is, patient health status and satisfaction, resulting from specific medical and health interventions. Attributing changes in outcomes to medical care requires distinguishing the effects of care from the effects of the many other factors that influence patients' health and satisfaction.

outlier
A hospital admission requiring either substantially more expense or a much longer length of stay than average. Under DRG reimbursement, outliers are given exceptional treatment (subject to peer review and organization review).

outpatient
A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility. Usually, it does not mean people receiving services from a physician's office or other program which also does not provide inpatient care.

P

participating physician
A physician who signs an agreement to accept assignment on all Medicare claims for one year. See assignment.

passive intervention
Health promotion and disease prevention initiatives which do not require the direct involvement of the individual (e.g., fluoridation programs) are termed "passive." Most often these types of initiatives are Government sponsored.

patient origin study
A study, generally undertaken by an individual health program or health planning agency, to determine the geographic distribution of the residences of the patients served by one or more health programs. Such studies help define catchment and medical trade areas and are useful in locating and planning the development of new services.

peer review
Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, and also to review of research by other researchers.

Per Member Per Month (PMPM)
A unit of measure referring to health plan costs, revenues, hospital days, or patient visits.

physician assistant (PA)
Also known as a physician extender, a PA is a specially trained and licensed or otherwise

credentialed individual who performs tasks, which might otherwise be performed by a physician, under the direction of a supervising physician.

physician-hospital organization (PHO)
A legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives. A PHO generally combines physicians and a hospital into a single organization for the purpose of obtaining payer contracts. Doctors maintain ownership of their practices and agree to accept managed care patients according to the terms of a professional services agreement with the PHO. The PHO serves as a collective negotiating and contracting unit. It is typically owned and governed jointly by a hospital and shareholder physicians.

Physician Payment Review Commission (PPRC)
Congress created the Physician Payment Review Commission in 1986 to advise it on reforms of the methods used to pay physicians under the Medicare program. The Commission has conducted analyses of physician payment issues and worked closely with the Congress to bring about comprehensive reforms in Medicare physician payment policy. Its recommendations formed the basis of 1989 legislation that created the RBRVS, a resource-based fee schedule limiting the amount physicians may charge patients.

point of service
A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of health care services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from HMO providers are less than when care is rendered by PPO or non-contracting providers.

portability
Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans.

practice guidelines, parameters
Standards used to guide providers based on accepted clinical treatment protocols for typical cases.

preadmission certification
A process under which admission to a health institution is reviewed in advance to determine need and appropriateness and to authorize a length of stay consistent with norms for the evaluation.

preexisting condition
A medical condition developed prior to issuance of a health insurance policy. Some policies exclude coverage of such conditions is often excluded for a period of time or indefinitely.

preferred provider arrangement (PPA)
Selective contracting with a limited number of health care providers, often at reduced or pre-negotiated rates of payment.

Preferred Provider Organization (PPO)
Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.

prepayment
Usually refers to any payment to a provider for anticipated services (such as an expectant mother paying in advance for maternity care). Sometimes prepayment is distinguished from insurance as referring to payment to organizations which, unlike an insurance company, take responsibility for arranging for, and providing, needed services as well as paying for them (such as health maintenance organizations, prepaid group practices, and medical foundations).

prevailing charge
One of the factors determining a physician's payment for a service under Medicare, set at a percentile of customary charges of all physicians in the locality.

prevalence
The number of cases of disease, infected persons, or persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It can be a measurement of morbidity at a moment in time, e.g., the number of cases of hemophilia in the country as of the first of the year.

preventive medicine
Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine developed following discovery of bacterial diseases and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of the environment. In particular, the promotion of health

through altering behavior, especially using health education, is gaining prominence as a component of preventive care.

primary care
Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

Primary Care Provider (PCP)
A generalist physician (family practice, general internal medicine, general pediatrics, and sometimes obstetrics/gynecology for women patients) who provides primary care services.

primary care case management (PCCM)
The use of a primary care physician to manage the use of medical or surgical care. PCCM programs usually pay for all care in a fee-for-service basis.

prospective payment
Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for a defined period (usually a year). Institutions are paid these amounts regardless of the costs they actually incur. These systems of payment are designed to introduce a degree of constraint on charge or costs increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs. Prospective payment contrasts with the method of payment originally used under Medicare and Medicaid (as well as other insurance programs) where institutions were reimbursed for actual expenses incurred.

Prospective Payment Assessment Commission (ProPAC)
In 1983, the Congress created the Prospective Payment Assessment Commission to advise the secretary of the Department of Health and Human Services on Medicare's *diagnosis related group*-based prospective payment system. Its members are appointed by the director of the Office of Technology Assessment. The commission's main responsibilities include recommending an appropriate annual percentage change in DRG payments; recommending needed changes in the DRG classification system and individual DRG weights; collecting and evaluating data on medical practices, patterns, and technology; and reporting on its activities.

provider
Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.

provider service organization (PSO)
See Provider Sponsored Network and Physician-Hospital Organization.

provider sponsored network (PSN)
Formal affiliations of providers, organized and operated to provide an integrated network of health care providers with which third parties, such as insurance companies, HMOs or other health plans, may contract for health care services to covered individuals. Some models of integration include Physician Hospital Organizations and Management Service Organizations.

public health
The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.

purchasing organization
See health insurance purchasing cooperative (HIPC).

Q

quality assurance reform initiative (QARI)
A process developed by the Health Care Financing Administration to develop a health care quality improvement system for Medicaid managed care plans.

quality of care
Can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the

probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

R

rate band
The allowable variation in insurance premiums as defined in state regulations. Acceptable variation may be expressed as a ratio from highest to lowest (e.g., 3:1) or as a percent from the community rate (e.g., +/-20%). Usually based on risk factors such as age, gender, occupation or residence.

rate review
Review by a government or private agency of a hospital's budget and financial data, performed for the purpose of determining the reasonableness of the hospital rates and evaluating proposed rate increases.

referral
The process of sending a patient from one practitioner to another for health care services. Health Plans may require that designated primary care providers authorize a referral for coverage of specialty services.

rehabilitation
The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical, and educational.

reimbursement
The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

reinsurance
The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

report card
A report presented on quality of health services designed to inform patients and health care purchasers of practitioner and organizational performance.

resource-based relative value scale (RBRVS)
Established as part of the Omnibus Reconciliation Act of 1989, Medicare payment rules for physician services was altered by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor, and a dollar conversion factor.

retrospective reimbursement
Payment made after-the-fact for services rendered on the basis of costs incurred by the facility. See also prospective payment.

risk
Responsibility for paying for or otherwise providing a level of health care services based on an unpredictable need for these services.

risk adjustment
A process by which premium dollars are shifted from a plan with relatively healthy enrollees to another with sicker members. It is intended to minimize any financial incentives health plans may have to select healthier than average enrollees. In this process, health plans which attract higher risk providers and members would be compensated for any differences in the proportion of their members that require high levels of care compared to other plans.

risk-bearing entity
An organization that assumes financial responsibility for the provision of a defined set of benefits by accepting prepayment for some or all of the cost of care. A risk-bearing entity may be an insurer, a health plan or self-funded employer; or a PHO or other form of PSN.

risk sharing
The distribution of financial risk among parties furnishing a service. For example, if a hospital and a group of physicians from a corporation provide health care at a fixed price, a risk-sharing arrangement would entail both the hospital and the group being held liable if expenses exceed revenues.

risk selection
Occurrence when a disproportionate share of high or low users of care join a health plan.

rural health network
Refers to any of a variety of organizational arrangements to link rural health care providers in a common purpose.

rural health clinic (RHC)
A public or private hospital, clinic or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act (Public Law 95-210). The practice must be located in a Medically Underserved area or a Health Professions Shortage Area and use a physician assistant and/or nurse practitioners to deliver services. A rural health clinic must be licensed by the state and provide preventive services.

Rural Health Clinics Act
Establishes a reimbursement mechanism to support the provision of primary care services in rural areas. Public Law 95-210 was enacted in 1977 and authorizes the expanded use of physician assistants, nurse practitioners and certified nurse practitioners; extends Medicare and Medicaid reimbursement to designated clinics; and raises Medicaid reimbursement levels to those set by Medicare.

S

screening
The use of quick procedures to differentiate apparently well persons who have a disease or a high risk of disease from those who probably do not have the disease. It is used to identify high risk individuals for more definitive study or follow-up. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons.

secondary opinions
In cases involving non-emergency or elective surgical procedures, the practice of seeking judgment of another physician in order to eliminate unnecessary surgery and contain the cost of medical care.

secondary care
Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists). In the U.S., however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers. This is quite different from the practice in England, for example, where all patients must first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as needed.

secondary prevention
Early diagnosis, treatment and follow-up. Secondary prevention activities start with the assumption that illness is already present and that primary prevention was not successful and the goal is to diminish the impact of disease or illness through early detection, diagnosis and treatment. For example, blood pressure screening, treatment, and follow up programs.

Section 1115 Medicaid Waiver
Section 1115 of the Social Security Act grants the secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects which are "likely to promote the objectives" of the program. Section 1115 demonstration waivers allow states to change provisions of their Medicaid programs, including: eligibility requirements, the scope of services available, the freedom to choose a provider, a provider's choice to participate in a plan, the method of reimbursing providers, and the statewide application of the program.

Section 1915(b) Medicaid Waiver
Section 1915(b) waivers allow states to require Medicaid recipients to enroll in HMOs or other managed care plans in an effort to control costs. The waivers allow states to: implement a primary care case-management system; require Medicaid recipients to choose from a number of competing health plans; provide additional benefits in exchange for savings resulting from recipients' use of cost-effective providers; and limit the providers from which beneficiaries can receive non-emergency treatment. The waivers are granted for two years, with two-year renewals. Often referred to as a "freedom-of-choice waiver"

self-funding / self-insurance
An employer or group of employers sets aside funds to cover the cost of health benefits for their employees. Benefits may be administered by the employer(s) or handled through an administrative service only agreement with an insurance carrier or third-party administrator. Under self-funding, it is generally possible to purchase stop-loss insurance that covers expenditures above a certain aggregate claim level and/or covers catastrophic illness or injury when individual claims reach a certain dollar threshold.

service period
Period of employment that may be required before an employee is eligible to participate in an employer-sponsored health plan, most commonly one to three months.

severity of illness
A risk prediction system to correlate the "seriousness" of a disease in a particular patient with the statistically "expected" outcome (e.g., mortality,

morbidity, efficiency of care). Most effectively, severity is measured at or soon after admission, before therapy is initiated, giving a measure of pre-treatment risk.

shadow pricing
Within a given employer group, pricing of premiums by HMO(s) based upon the cost of indemnity insurance coverage, rather than strict adherence to community rating or experience rating criteria.

shared services
The coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or nonmedical services on the part of two or more otherwise independent hospitals or other health programs. The sharing of medical services might include an agreement that one hospital provide all pediatric care needed in a community and no obstetrical services while another provide obstetrics and no pediatrics. Examples of shared nonmedical services would include joint laundry or dietary services for two or more nursing homes.

skilled nursing facility (SNF)
A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.

small-group market
The insurance market for products sold to groups that are smaller than a specified size, typically employer groups. The size of groups included usually depends on state insurance laws and thus varies from state to state, with 50 employees the most common size.

sole community hospital (SCH)
A hospital which (1) is more than 50 miles from any similar hospital, (2) is 25 to 50 miles from a similar hospital and isolated from it at least one month a year as by snow, or is the exclusive provider of services to at least 75 percent of its service area populations, (3) is 15 to 25 miles from any similar hospital and is isolated from it at least one month a year, or (4) has been designated as an SCH under previous rules. The Medicare DRG program makes special optional payment provisions for SCHs, most of which are rural, including providing that their rates are set

permanently so that 75 percent of their payment is hospital-specific and only 25 percent is based on regional DRG rates.

solo practice
Lawful practice of a health occupation as a self-employed individual. Solo practice is by definition private practice but is not necessarily general practice or fee-for-service practice (solo practitioners may be paid by capitation, although fee-for-service is more common). Solo practice is common among physicians, dentists, podiatrists, optometrists, and pharmacists.

specialist
A physician, dentist, or other health professional who is specially trained in a certain branch of medicine or dentistry related to specific services or procedures (e.g., surgery, radiology, pathology); certain age categories of patients (e.g., geriatrics); certain body systems (e.g., dermatology, orthopedics, cardiology); or certain types of diseases (e.g., allergy, periodontics). Specialists usually have advanced education and training related to their specialties.

spend down
The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in States that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.

State Children's Health Insurance Program (SCHIP)
This program was enacted as part of the Balanced Budget Act of 1997, which established Title XXI of the Social Security Act to provide States with $24 billion in Federal funds for 1998-2002 targeting children in families with incomes up to 200 percent of the Federal Poverty Level.

Substance Abuse and Mental Health Services Administration (SAMHSA)
The mission of SAMHSA is to provide, through the U.S. Public Health Service, a national focus for the Federal effort to promote effective strategies for the prevention and treatment of addictive and mental disorders. SAMHSA is primarily a grant-making organization, promoting knowledge and scientific state-of-the-art practice. SAMHSA strives to reduce barriers to high quality, effective programs and services for individuals who suffer from, or are at risk for, these disorders, as well as for their families and communities.

Supplemental Security Income (SSI)
A federal cash assistance program for low-income aged, blind and disabled individuals established by Title XVI of the Social Security Act. States may use SSI income limits to establish Medicaid eligibility.

T

technology assessment
A comprehensive form of policy research that examines the technical, economic, and social consequences of technological applications. It is especially concerned with unintended, indirect, or delayed social impacts. In health policy, the term has

come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety.

telemedicine
The use of telecommunications (i.e., wire, radio, optical or electromagnetic channels transmitting voice, data and video) to facilitate medical diagnosis, patient care, and/or distance learning.

Temporary Assistance to Needy Families (TANF)
Title I of the Welfare Reform Act of 1996 converts Federal funding under the former AFDC to a State block grant program called TANF.

tertiary care
Services provided by highly specialized providers (e.g., neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require highly sophisticated equipment and support facilities. The development of these services has largely been a function of diagnostic and therapeutic advances attained through basic and clinical biomedical research.

tertiary prevention
Prevention activities which focus on the individual after a disease or illness has manifested itself. The goal is to reduce long-term effects and help individuals better cope with symptoms.

third-party payer
Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

third-party administrator (TPA)
A fiscal intermediary, a person or an organization that serves as another's financial agent. A TPA processes claims, provides services, and issues payments on behalf of certain private, federal and state health benefit programs or other insurance organizations.

Title XVIII (Medicare)
The title of the Social Security Act which contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Title XIX (Medicaid)
The title of the Social Security Act which contains the principal legislative authority for the Medicaid program and therefore a common name for the program.

U

uncompensated care
Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.

underinsured
People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

uninsured
People who lack public or private health insurance.

usual, customary and reasonable (UCR) fees
The use of fee screens to determine the lowest value of physician reimbursement based on: (1) the physician's usual charge for a given procedure, (2) the amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case.

utilization
Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.

utilization review
Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a peer review group, or a public agency.

V

vertical integration
Organization of production whereby one business entity controls or owns all stages of the production and distribution of goods or services.

vital statistics
Statistics relating to births (natality), deaths (mortality), marriages, health, and disease (morbidity). Vital statistics for the United States are published by the National Center for Health Statistics.

W

wellness
A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.

withhold
A form of compensation whereby a health plan withholds payment to a provider until the end of a period at which time the plan distributes any surplus based on some measure of provider efficiency or performance.

EPIDEMIOLOGICAL AND STATISTICAL TERMS

A

association
A term signifying a relationship between two or more events or variables. Events are said to be associated when they occur more frequently together than one would expect by chance. Association does not necessarily imply a casual relationship. Statistical significance testing enables a researcher to determine the likelihood of observing the sample relationship by chance if in fact no association exists in the population that was sampled. The terms "association" and "relationship" are often used interchangeably.

C

causality
Relating causes to the effects they produce. Most of epidemiology concerns causality, and several types of causes can be distinguished. A cause is termed "necessary" when a particular variable must always precede an effect. This effect need not be the sole result of the one variable. A cause is termed "sufficient" when a particular variable inevitably initiates or produces an effect. Any given cause may be necessary, sufficient, neither, or both.

confidence interval
A range within which an estimate is deemed to be close to the actual value being measured. In statistical measurements, estimates cannot be said to be exact matches, but rather are defined in terms of their probability of matching the value of the thing being measured.

E

etiology
Cause. A term used by epidemiologists.

P

precision
In statistics, the quality of being sharply defined or stated. One measure of precision is the number of distinguishable alternatives from which a measurement was selected, sometimes indicated by the number of significant digits in the measurement. Precision can be contrasted with accuracy, which is the degree of conformity of a measure to a standard or true value. Often, however, this contrast is not relevant, because the true value is not known.

probability (P value)
The likelihood that an event will occur. When looking at differences between data samples, statistical techniques are used to determine if the differences are likely to reflect real differences in the whole group from which the sample is drawn or if they are simply the result of random variation in the samples. For example, a probability (or P value) of one percent indicates that the differences observed would have occurred by chance in one out of a hundred samples drawn from the same data.

R

rate
A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates are usually expressed using a standard denominator such as 1,000 or 100,000 persons.

regression analysis
Regression analysis is a tool used by economists and others to estimate the relationships among a dependent variable Y and one (or many) independent variable(s) X. The purpose of regression analysis is the "best fit" data points from a straight line down on an XY graph.

relative risk
The rate of disease in one group exposed to a particular factor (e.g., a toxic spill) divided by the rate in another group which is not exposed. A relative risk of one (1) indicates that the two groups have the same rate of disease.

risk or risk factor
Risk is a term used by epidemiologists to quantify the likelihood that something will occur. A risk factor is something which either increases or decreases an individual's risk of developing a disease. However, it does not mean that, if exposed, an individual will definitely contract a particular disease.

S

standard error
In statistics, the standard error is defined as the standard deviation of an estimate. That is, multiple measurements of a given value will generally group around the mean (or average) value in a normal distribution. The shape of this distribution is known as the standard error.

survey
An investigation in which information is systematically collected. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, by postal service, or in some other way. Each method has its advantages and disadvantages. The generalizability of results depends upon the extent to which those surveyed are representative of the entire population.

T

type I error
Also known as "false positive" or "alpha error." An incorrect judgment or conclusion that occurs when an association is found between variables where, in fact, no association exists. In an experiment, for example, if the experimental procedure does not really have any effect, chance or random error may cause the researcher to conclude that the experimental procedure did have an effect.

type II error
Also known as "false negative" or "beta error." An incorrect judgement or conclusion that occurs when no association is found between variables where in fact, an association does exist. In a medical screening, for example, a negative test result may occur by chance in a subject who possesses the attribute for which the test is conducted.

ACCOUNTING AND ECONOMIC TERMS

A

amortization
The act or process of retiring a debt, usually by equal payments at regular intervals over a specific period of time.

C

capital costs
Expenditures for land, facilities, and major equipment. They are distinguished from operating costs, which include such items as labor, supplies, and administrative expenses.

capital depreciation
The decline in value of capital assets (assets of a permanent or fixed nature, e.g., goods and plant) with use over time. The rate and amount of depreciation is calculated by a variety of different methods (e.g., straight line, sum of the digits, declining balance) which often give quite different results. Third-party reimbursement for health services usually includes an amount intended to be equivalent to the capital depreciation in any given period experienced by the provider of a service.

capital expenditure
An expenditure for the acquisition, replacement, modernization, or expansion of facilities or equipment which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

competition
A characteristic of market economics in which buyers choose from among alternative goods and services made available in the market by two or more sellers. In a classic competitive market, there are many buyers and many sellers.

consumer
One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is not associated in any direct or indirect way with the provision of health services.

contractual allowance
The difference between what hospitals bill and what they receive in payment from third party payers, most commonly government programs; also known as contractual adjustment.

contribution margin
Revenue from sales less all variable expenses.

cost
Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an individual or third party, may or may not be equal to service costs.

cost of goods sold
Inventoriable costs that are expensed because the units are sold; equals beginning inventory plus cost of goods purchased or manufactured minus ending inventory.

current cost
Cost stated in terms of current values (of productive capacity) rather than in terms of acquisition cost.

D

debt service
Required payments for interest on and retirement of a debt; the amount needed, supplied, or accrued for meeting such payments during any given accounting period; a budget or operating statement heading for such items.

default
Failure to pay debt service when due.

demand
In health economics, the amount of a good or service consumers are willing and able to buy at varying prices, given constant income and other factors. Demand should be distinguished from utilization (the amount of services actually used) and need (which has a normative connotation and relates to the amount of goods or services which should be consumed based on professional value judgments).

direct cost
A cost which is identifiable directly with a particular activity, service, or product of the program experiencing the costs. These costs do not include the allocation of costs to a cost center which are not specifically attributable to that cost center.

F

financial feasibility
The projected ability of a provider to pay the capital and operating costs associated with the delivery of a proposed health care service.

G

gross margin
Net sales minus goods sold; the difference between sales revenues and manufacturing costs as an intermediate step in the computation of operating profits or net income.

I

indirect cost
A cost which cannot be identified directly with a particular activity, service, or product of the entity incurring the cost. Indirect costs are usually apportioned among an entity's services in proportion to each service's share of direct costs.

interest
The cost incurred for borrowing funds. Interest is usually expressed as a percentage of the total loan.

inventory
A detailed description of quantities and locations of different kinds of facilities, major equipment, and personnel which are available in a geographic area and the amount, type, and distribution of services these resources can support.

M

margin
Revenue less specified expenses.

O

operating cost
In the health field, the financial requirements necessary to operate an activity which provides health services. These costs normally include the costs of personnel, materials, overhead, depreciation, and interest.

operating margin
Revenues from sales minus current cost of goods sold. A measure of operating efficiency that is independent of the cost flow assumption for inventory. Sometimes called "current (gross) margin."

overhead
The general costs of operating an entity which are allocated to all the revenue producing operations of the entity but which are not directly attributable to a single activity. For a hospital, these costs normally include maintenance of plant, occupancy costs, housekeeping, administration, and others.

P

proprietary
Profit making; owned and operated for the purpose of making a profit, whether or not one is actually made.

public good
A good or service whose benefits may be provided to a group at no more cost than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded. For example, a public health measure that eradicates smallpox protects all, not just those paying for the vaccination.

R

revenue
The gross amount of earnings received by an entity for the operation of a specific activity. It does not include any deductions for such items as expenses, bad debts, or contractual allowances.

S

supply
In health economics, the quantity of services provided or personnel in a given area.

W

working capital
The sum of an institution's short-term or current assets including cash, marketable (short-term) securities, accounts receivable, and inventories. Net working capital is defined as the excess of total current assets over total current liabilities.

ACRONYMS

AAMC	Association of American Medical Colleges; Association of American Medical Clinics
AAPCC	Adjusted Average Per Capita Cost
AAPS	American Association of Physicians and Surgeons
ADA	American Dietetic Association; American Dental Association
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AGPA	American Group Practice Association
AHCPR	Agency for Health Care Policy and Research
AHEC	Area Health Education Center
ANA	American Nurses Association
AHA	American Hospital Association
ANHA	American Nursing Homes Association
AOA	American Optometric Association; American Osteopathic Association
APA	Administrative Procedures Act
APDRG	All Patient Diagnosis Related Groups
	American Pharmaceutical Association
APHA	American Public Health Associations;
APHA	American Protestant Hospital Association
ASTHO	Association of State and Territorial Health Officials
BCA	Blue Cross Association
CAP	Community Action Program
CAT	Computerized Axial Tomography
CBO	Congressional Budget Office
CCHP	Consumer Choice Health Plan
CCU	Coronary Care Unit
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHMIS	Community Health Management Information System
CHC	Community Health Center
CMHC	Community Mental Heath Center
CME	Continuing Medical Education
CMP	Competitive Medical Plan
COB	Coordination of Benefits
COG	Council of Governments
CON	Certificate of Need
COPC	Community Oriented Primary Care
(D)HHS	Department of Health and Human
COTH	Council of Teaching Hospitals
CPA	Certified Public Accounts
CPHA	Commission on Professional and Hospital Activities
CPI	Consumer Price Index
CPR	Customary, Prevailing, and Reasonable
CPT-4	Current Procedural Terminology, Fourth Edition
CRVS	California Relative Value Studies
CT	Computer Tomographic (scanners)
DD	Developmental Disability
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Administration
DMD	Doctor of Dental Medicine
DO	Doctor of Osteoathy
DRG	Diagnosis-Related Group
DVM	Doctor of Veterinary Medicine
ECF	Extended Care Facility
EDI	Electronic Data Interchange
EMS	Emergency Medical Services
EPA	Exclusive Provider Arrangement
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment Program
ER	Emergency Room
ERISA	Employee Retirement Income Security Act
ESRD	End Stage Renal Disease
ET	Expenditure Target
FAH	Federation of American Hospitals
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FICA	Federal Insurance Contributions Act
FMG	Foreign Medical Graduate
FNP	Family Nurse Practitioner
FTC	Federal Trade Commission
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GHAA	Group Health Association of America
GP	General Practitioner
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set

	Services
HIAA	Health Insurance Association of America
HIPC	Health Insurance Purchasing Cooperative
HMO	Health Maintenance Organization
HMSA	Health Manpower Shortage Area
HRSA	Health Resources & Services Administration
HSA	Health Systems Agency; Health Service Area
IADL	Instrumental Activities of Daily Living
IBNR	Incurred But Not Reported
ICDA	International Classification of Diseases, Adapted
ICF	Intermediate Care Facility
ICU	Intensive Care Unit
ICU/MR	Intermediate Care Facility for the Mentally Retarded
IOM	Institute of Medicine of the National Academy of Sciences
IPA	Independent Practice Association
ISN	Integrated Services Network
JCAHO	Joint Commission on Accreditation of Healthcare
LOS	Length of Stay
LPN	License Practical Nurse
LSC	Life Safety Code
LVN	License Vocational Nurse
MAAC	Maximum Allowable Actual Change
MAF	Medical Assistance Facility
MAP	Medical Audit Program
MCAT	Medical College Admission Test
MCH	Maternal and Child Health Program
MEDLARS	Medical Literature and Analysis Retrieval System
MET	Multiple Employer Trust
MEWA	Multiple Employer Welfare Arrangement
MMIS	Medical Management Information System
MR	Mentally Retarded
MRI	Magnetic Resonance Imaging
MSA	Medical Savings Account
MSA	Metropolitan Statistical Areas
NACo	National Association of Counties
NCHS	National Center for Health Statistics
NCHSR/ HCTA	National Center for Health Services Research/Health Care Technology Assessment
NCQA	National Committee for Quality Assurance
NGA	National Governor's Association
NHSC	National Health Services Corps
NICU	Neonatal Intensive Care Unit
NIH	National Institute of Health
NIMH	National Institute of Mental Health
NIOSH	National Institute of Occupational Safety and Health
NLM	National Library of Medicine
NP	Nurse Practitioner
NPRM	Notice of Proposed Rulemaking
OAA	Old Age Assistance
OASDHI	Old Age Survivors, Disability, and Health Insurance Program
ODS	Organized Delivery System
OMB	Office of Management and Budget
OPD	Outpatient Department
PCCM	Primary Care Case Management
PHO	Physician-Hospital Organization
QARI	Quality Assurance Reform Initiative
RAN	Rural Area Computer Network
RHC	Rural Health Clinic
SAMHSA	Substance Abuse and Mental Health Services Administration
VIRHN	Vertically Integrated Rural Health Network

ALPHA CENTER

Additional List of Health Care Acronyms and Terms

CPS — **Current Population Survey**
A national survey conducted annually by the U.S. Department of Commerce, Bureau of the Census, the CPS gathers information on the noninstitutionalized population of the United States. The CPS is the most commonly reported source for the number of persons without health insurance and other information about this population.

FPL — **Federal Poverty Level**
Poverty guidelines are established by the Department of Health and Human Services and are issued each year in the *Federal Register*. They are used to determine individuals' and families' eligibility for various Federal and non-Federal programs. They are the same in the 48 contiguous States and the District of Columbia and are higher in Alaska and Hawaii.

HIPAA — **Health Insurance Portability and Accountability Act of 1996**
Sometimes called the Kennedy-Kassenbaum bill, this legislation sets a precedent for Federal involvement in insurance regulation. It sets minimum standards for regulation of the small group insurance market and for a set group in the individual insurance market in the area of portability and availability of health insurance.

PCP — **Primary Care Provider**
A generalist physician (family practice, general internal medicine, general pediatrics, and sometimes obstetrics/gynecology for women patients) who provides primary care services.

PMPM — **Per Member Per Month**
A unit of measure referring to health plan costs, revenues, hospital days, or patient visits.

SCHIP — **State Children's Health Insurance Program**
This new program was enacted as part of the Balanced Budget Act of 1997, which established Title XXI of the Social Security Act to provide States with $24 billion in Federal funds for 1998-2002 targeting children in families with incomes up to 200 percent of the Federal Poverty Level.

TANF — **Temporary Assistance to Needy Families**
Title I of the Welfare Reform Act of 1996 converts Federal funding under the former AFDC to a State block grant program called TANF.

Voting Sheets

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 1119

BILL TITLE: **establising a commission to investigate health care issues.**

DATE: March 9, 2000

LOB ROOM: 302

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, (ITL), Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Francoeur

Seconded by Rep. Marshall

Vote: 20-0 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: Yes 20/0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Stephen G. Avery, Clerk

Stephen G. Avery

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 1119

BILL TITLE: **establising a commission to investigate health care issues.**

DATE: 3-9-00

LOB ROOM:

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Francour

Seconded by Rep. Marshall

Vote: (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: {Type VOTE} 20-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Stephen G. Avery, Clerk

OFFICE OF THE HOUSE CLERK 2000 SESSION

COMMERCE

Bill #: 1119 **Title:** est. a commission to investigate health care issues

PH Date: ___/___/___ **Exec Session Date:** 3/9/00

Motion: ITL **Amendment #:**

MEMBER	YEAS	NAYS
Hunt, John B, Chairman		
Francoeur, Sheila T, V Chairman	✓	
Herman, Keith R	✓	
Tsiros, William B	✓	
Belanger, Ronald J	✓	
McGough, Tim S	✓	
Avery, Stephen G, Clerk	✓	
Kenney, Joseph D	✓	
Langley, Jane S	✓	
Pappas, Marc P	✓	
Dalianis, Griffin T	✓	
DiFruscia, Anthony R	✓	
Marshall, Gene B	✓	
Clark, Martha Fuller	✓	
Crosby, Toni M	✓	
Russell, Ronald G	✓	
Reardon, Tara G	✓	
Vachon, Dennis P	✓	
Taylor, Kathleen N	✓	
Curran, James C		
Garrish, Linda L	✓	
Keye, Harvey	✓	
TOTAL VOTE:	20	0

Printed: 12/30/1999

Committee Report

COMMITTEE REPORT

COMMITTEE: **Commerce**

BILL NUMBER: **HB 1119**

TITLE: establishing a commission to investigate health care issues.

DATE: March 9, 2000 CONSENT CALENDAR YES ☒ NO ☐

☐ OUGHT TO PASS

☐ OUGHT TO PASS WITH AMENDMENT

☒ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

This bill would have established a three-year commission to investigate health care issues. The committee agrees with the sponsors concerning the current status of the health care industry in the State of New Hampshire and has agreed to look into these issues in the extended and expanded chapter study requested in HB 1183.

Vote 20-0.

Rep. Sheila T. Francoeur
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

CONSENT CALENDAR

Commerce

HB 1119, establishing a commission to investigate health care issues. INEXPEDIENT TO LEGISLATE

Rep. Sheila T. Francoeur for Commerce: This bill would have established a three-year commission to investigate health care issues. The committee agrees with the sponsors concerning the current status of the health care industry in the State of New Hampshire and has agreed to look into these issues in the extended and expanded chapter study requested in HB 1183. Vote 20-0.