Bill as Introduced

SB 162 – AS INTRODUCED

1999 SESSION

99-0601
01/09

SENATE BILL ***162***

AN ACT establishing the voluntary small employer health insurance purchasing alliance.

SPONSORS: Sen. Fraser, Dist 4; Sen. Trombly, Dist 7

COMMITTEE: Insurance

ANALYSIS

This bill establishes the New Hampshire voluntary small employer purchasing alliance to provide, on a voluntary basis, health insurance coverage to member small employers and their employees in New Hampshire.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

99-0601
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord One Thousand Nine Hundred and Ninety-Nine

AN ACT establishing the voluntary small employer health insurance purchasing alliance.

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

1 New Chapter; The Voluntary Small Employer Health Insurance Purchasing Alliance Act. Amend RSA by inserting after chapter 420-J the following new chapter:

CHAPTER 420-K

THE VOLUNTARY SMALL EMPLOYER HEALTH INSURANCE PURCHASING ALLIANCE ACT

420-K:1 Purpose. The purpose and intent of this chapter is to:

I. Increase the affordability, efficiency, and fairness of health care coverage for small employers by providing for the establishment of a statewide purchasing alliance through which small employers and their employees may purchase health coverage in the manner of large employer groups.

II. Allow small employers and their employees to obtain better value in purchasing health insurance by consolidating purchasing responsibilities and resources, thereby increasing bargaining power and purchasing expertise and reducing the administrative cost of health plan contracting, enrollment, premium collection and payment for multiple employers.

III. Provide small employers and their employees a meaningful choice of health carriers and health benefit plans through an open and fair process in which qualified carriers compete to provide health coverage to alliance members.

IV. Foster competition based on value by:

(a) Providing consumers with clear information about health carriers and coverages, including performance measurement and consumer satisfaction data;

(b) Requiring carriers to offer standardized coverages for meaningful comparison; and

(c) Reducing the incentive and opportunity for health carriers to engage in risk selection and cost-shifting from other purchasers.

420-K:2 Definitions. In this chapter:

I. "Commissioner" means the insurance commissioner.

II. "Eligible dependent" means "eligible dependents" as defined in RSA 420-G:2, V.

III. "Eligible employee" means "eligible employees" as defined in RSA 420-G:2, VI.

IV. "Employee enrollee" means an eligible employee, self-employed individual or an eligible dependent of an eligible employee who is enrolled in a health benefit plan offered through the alliance by a participating carrier.

V. "Health benefit plan" means "health coverage" as defined in RSA 420-G:2, IX.

VI. "Health carrier" means "health carrier" as defined in RSA 420-G:2, VIII.

VII. "Member small employer" means a small employer who enrolls in the alliance.

VIII. "Participating carrier" means a carrier deemed by the alliance as meeting the requirements of RSA 420-K:6 and in contract with the alliance.

IX. "Purchasing alliance" or "alliance" means the New Hampshire voluntary small employer purchasing alliance, a non-risk bearing, nonprofit corporation that provides, on a voluntary basis, health insurance coverage through multiple unaffiliated participating carriers to member small employers and their employees throughout New Hampshire.

X. "Small employer" means "small employer" as defined in RSA 420-G:2, XVI.

420-K:3 Jurisdiction of the Commissioner.

I. The commissioner shall have the authority to regulate the establishment and conduct of the alliance authorized under this chapter.

II. Nothing in this chapter shall be deemed to be in conflict with or limit the powers granted to the commissioner under the laws of this state.

420-K:4 Alliance Establishment and Oversight.

I. The commissioner shall:

(a) Issue a request for proposals that solicits nonprofit entities established under RSA 292 to submit bids to assume administrative and fiscal responsibility for the operation of the alliance. The commissioner shall assess bidder's qualifications in the areas of administrative capacity, financial responsibility, and demonstrated ability to fulfill the purposes and requirements of this chapter. Within 6 months of issuing the request for proposals, the commissioner shall select from among the qualified bidders and award administrative and financial responsibility for the operation of the alliance to the selected nonprofit entity. If no qualified nonprofit entity submits a bid pursuant to the commissioner's request for proposals, the commissioner may reissue a request for proposals at any time if the commissioner has reason to believe that there is a possibility of a response from a qualified nonprofit entity.

(b) Include in the request for proposals issued pursuant to RSA 420-K:4, I(a), a requirement that applicants submit at least the following information and documents with their response:

(1) A business plan consisting of a detailed, written plan of operations explaining how the applicant intends to fulfill the purposes and requirements of this chapter. Material changes in policy or operations of the business plan are subject to the prior approval of the commissioner on the same basis as the original business plan;

(2) The applicant's nonprofit articles of incorporation, bylaws and other formation and business operation documents. An applicant shall demonstrate to the satisfaction of the commissioner that its corporate governance makes it an appropriate and effective representative of small employers and their eligible employees' interests. An applicant shall demonstrate that it is not merely a marketing or distribution channel for a single product or the products of a single carrier and that it will organize and facilitate meaningful competition between multiple unaffiliated carriers;

(3) A list of officers and directors of the applicant and the contract administrator, if one is employed, and personal biographical information or firm descriptions for each. The personal biographical information and firm descriptions shall demonstrate that those involved in the operation of the alliance have the expertise, experience, and character to effectively and professionally represent small employers and their eligible employees in a fiduciary capacity;

(4) Evidence of adequate security and prudence in the accounting, deposit, collection, handling, and transfer of moneys. An applicant shall affirmatively demonstrate adequate financial controls to the satisfaction of the commissioner; and

(5) Any other information required by the commissioner and deemed pertinent to the policies and operation of the alliance.

(c) Specify the information and documents that the alliance will be required to submit to the commissioner on a periodic basis to enable the commissioner to perform its oversight function. This shall include at least the following information and documents:

(1) Quarterly financial statements and annual reports designed to ensure that the alliance is fulfilling the purposes and requirements of this chapter, is adequately representing the interests of small employers and their eligible employees, is operating in a sound financial fashion, is not a risk-bearing entity, is utilizing sound financial controls and money management, and is not mismanaging or misappropriating funds either through neglect or malfeasance;

(2) Proposed material changes in the policy or operations of the business plan. Such proposed changes are subject to approval by the commissioner prior to implementation by the alliance; and

(3) Any other information required by the commissioner and deemed pertinent to the policies and operation of the alliance.

(d) Develop standard procedures for the resolution of disputes between the alliance and participating carriers, and between the alliance and member small employers or their eligible employees.

(e) Prepare an annual report on the operations of the alliance for the governor, the presiding officers of the legislature, the commissioner of health and human services, and the commissioner of insurance including program and financial operations and an accounting of outside revenues received and all internal and independent audits.

II. The commissioner may:

(a) Approve all assessments made upon member small employers by the alliance for costs incurred or anticipated in connection with the operation of the alliance.

(b) If review by the commissioner reveals that the entity selected to administer the alliance is not in compliance with the provisions of this chapter or is not acting in the best interests of its enrollees or has failed to comply with a lawful order of the commissioner, relieve that entity of its duties and in the interim may assume, or appoint another entity to assume, the duties of the alliance until a new administrator is appointed.

(c) In the event the alliance becomes insolvent, the commissioner may place the alliance in receivership for the purpose of protecting the interests of alliance enrollees.

(d) Exercise all other powers reasonably necessary to carry out the provisions of this chapter.

420-K:5 Powers and Duties of and Restrictions on the Purchasing Alliance.

I. The entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance shall:

(a) Establish and operate the alliance as a statewide entity offering health benefit plans that are available to all small employers in the state.

(b) Establish administrative and accounting procedures for operating the alliance, for providing services to member small employers and enrollees and for preparing an annual budget.

(c) Develop standard enrollment procedures for enrolling small employers and their eligible employees and dependents.

(d) Establish procedures for annual or rolling open enrollment periods during which:

(1) An enrollee may elect to enroll in any other health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works; and

(2) Any late enrollees may elect to enroll in any health benefit plan that is available through the purchasing alliance and that provides health coverage where he or she lives or works.

(e) Establish procedures and mechanisms for billing and collection of premiums from member small employers, including any share of the premium paid by employee enrollees.

(f) Establish conditions of participation for small employers which conform to the requirements of this chapter and RSA 420-G and include, but are not limited to, the following.

(1) Assurances that the member small employer is a valid small employer group and is not formed for the purpose of securing health benefits coverage.

(2) Prepayment of premiums or other mechanisms to assure that payment will be made for coverage.

(g) In enrolling member small employers, the alliance shall provide that each eligible employee is permitted to enroll in any health benefit plan offered by any participating carrier so long as the health benefit plan provides coverage where he or she works or lives.

(h) Establish conditions of participation for participating carriers.

(i) Develop model contracts which detail for potential contractors the requirements of the alliance and provide a copy of the contract to interested carriers.

(j) Develop and make available a list of objective criteria that shall be met by participating carriers in order to be eligible to participate in the alliance.

(k) Establish conditions of participation for agents or brokers.

(l) Define a set of standardized health benefit plans which the alliance will contract to purchase from participating carriers. A participating carrier contracting to provide one or more such benefit plans through the alliance shall be deemed to be in compliance with the guaranteed issue and renewability requirements in RSA 420-G:6, III with respect to such benefit plan or plans so long as it actively markets, issues, and renews such plan or plans to all eligible employees of all member small employers of the alliance.

(m) Except as provided herein, contract, through an open and fair competitive process, with at least 3 unaffiliated participating carriers in each regional service area of the state to ensure that enrollees have a choice from among a reasonable number of differing types of competing carriers and health benefit plans. The alliance may contract with less than 3 participating carriers in a given service area if the commissioner determines that it is impracticable or otherwise inconsistent with the interests of enrollees to attempt to contract with 3 or more participating carriers.

(n) Place into its contracts between the alliance and member small employers the following:

(1) For administrative purposes, the alliance shall be the policyholder or contract holder of the health benefit plan on behalf of member small employers, their eligible employees and eligible dependents;

(2) Provide that the participating carrier shall issue a certificate of coverage, or equivalent document, specifying the essential features of the health benefit plan's coverage to each enrolled eligible employee; and

(o) Provide to alliance members clear, standardized information on each participating carrier and the qualified health benefit plans offered by each participating carrier, including information on price, benefits, enrollee costs, quality, patient satisfaction, enrollment, grievance procedures and rights and responsibilities. Furthermore, the alliance shall provide qualified health benefit plan comparison sheets to participating members and their employees with information regarding coverage that may be obtained through the participating carriers.

(p) Transmit enrollment and eligibility information to participating carriers on a timely basis.

(q) Provide that in the event a member small employer terminates coverage purchased through the alliance, the former member small employer shall be ineligible to purchase a health benefit plan through the alliance for a predetermined period of time to be established by the commissioner.

(r) Develop uniform standards for data to be provided by participating carriers. In formulating such standards, the alliance shall strive for consistency with health care data collection activities underway in New Hampshire and nationally. Any data collection requirements promulgated by the commissioner shall be based on a determination of their feasibility and cost-effectiveness, including their consistency with national standards for electronic data interchange, and their necessity for supporting the evaluation of participating carriers and their provider networks with respect to cost containment, quality, control of expensive technology, and customer satisfaction.

(s) Specify in contracts with participating carriers how all premiums shall be transmitted and the frequency of that transmission, along with appropriate language for penalties and grace periods on late payments of premiums.

(t) Request from the commissioner certification that all participating carriers are licensed small group carriers and that the carriers satisfy the financial requirements established under state law.

(u) Maintain a trust account or accounts for deposit of all moneys received and collected for the operation of the alliance. The alliance, its board members, employees and agents shall have a fiduciary duty with respect to all moneys received or owed to it to assure payments of its obligations and a full accounting to its members and the commissioner.

(v) Assure the offering of the same premiums and prices on negotiated health care coverage to all member classes equally, and treat all members within a class equally with regard to membership and administrative fees and benefits of membership.

(w) Review information and recommendations from consumers, employers, participating carriers or health care providers and other sources and, as appropriate, issue periodic reports or recommendations to the commissioner to improve the delivery of health services and the purchasing of health coverage.

(x) Submit to the commissioner, on a periodic basis as determined by the commissioner, quarterly financial statements, annual reports, proposed material changes in the policy or operations of the business plan, and any other information required by the commissioner regarding the policies and operation of the alliance.

II. The entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance may:

(a) Receive, review, and act, as appropriate, on grievances against participating carriers by member small employers or enrollees.

(b) Undertake any activity necessary to administer the alliance, including marketing and publicizing the alliance, and assuring that participating carriers, participating small employers, and enrollees are in compliance with alliance requirements.

(c) Establish contracts with participating carriers to provide health coverage to alliance members. The alliance shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments. The alliance may establish performance standards for specific contractual elements and penalties for failure to fulfill contractual obligations.

(d) Establish contracts with small employer members.

(e) Contract with qualified, independent third parties for services necessary to carry out the powers and duties of the alliance.

(f) Enter into all other contracts as are necessary to carry out the powers and duties of the alliance.

(g) Appoint a beneficiary advisory council to evaluate alliance functions and the performance of participating carriers in order to assess the efficacy of the operations for member small employers and enrollees.

(h) Appoint advisory committees, as necessary, to provide technical assistance in the operation of the program and in carrying out the purposes of this chapter.

(i) Assess member small employers a reasonable fee for costs incurred or anticipated in connection with the operation of the alliance.

(j) Require as a condition of membership that all employers include all their eligible employees or a minimum percentage of employees in coverage purchased through the alliance. The alliance may require an employer making membership application to the purchasing alliance that would entail entering fewer than 100 percent of the employer's eligible employees or dependents to demonstrate that the resultant membership will not result in an adverse selection group being brought into the alliance or that the action would otherwise function as a form of risk selection or risk avoidance.

(k) Reject or allow a carrier to reject an employer from membership or drop or allow a carrier to drop a member small employer if the member employer or any of its eligible employees fail to pay premiums or engage in fraud or material misrepresentation in connection with a health benefit plan purchased through the alliance. If a member small employer or enrollee is dropped from coverage, the enrollee shall be entitled to continuation and conversion coverage to the extent provided for under applicable state and federal continuation laws and the state conversion law.

(l) Contract with licensed insurance agents or brokers to market and service coverage made available through the alliance to its members. Compensation for agents and brokers may not vary based on the actual or expected health status or medical utilization of the group to which coverage is sold.

(m) Exclude a carrier or freeze enrollment in a carrier for failure to achieve established quality, access or information reporting standards of the alliance.

(n) Require that member employers and their eligible employees continue to pay administrative fees that are part of the contract with the alliance if a member employer or enrollee cancels prior to completion of a contract period.

(o) Negotiate with participating carriers the premium rates charged for coverage offered through the alliance consistent with RSA 420-K:6.

(p) Request such information from participating carriers as is necessary to carry out the powers and duties of this chapter.

(q) Sue or be sued, including taking action necessary for securing legal remedies on behalf of the alliance, member small employers, or enrollees.

(r) Apply for loans or loan guarantees from the New Hampshire business finance authority under RSA 162-A for the purpose of funding startup costs.

(s) Receive and accept loans, grants, funds, or anything of value from a public or private entity. This shall include:

(1) Employer premiums;

(2) Employer participation fees;

(3) Employer late fees;

(4) Employer reinstatement fees;

(5) Agent and broker fees paid by the employer;

(6) Interest earned on accounts;

(7) Funds paid by the participating carriers for a pooled marketing effort;

(8) Public sector and private sector grants, gifts, loans or donations; or

(9) Other lawful sources.

(t) The alliance may also receive and accept contributions from a legitimate source of property, labor, or any other thing of value. The alliance, however, shall not accept anything of value from a person or entity that has a vested interest in its decisions.

(u) Expend funds to pay:

(1) Participating carriers under their contracts.

(2) Third parties for services provided under contract.

(3) Employer billing adjustments.

(4) Agent and broker fees.

(5) The alliance's administrative expenses.

(6) All other expenditures duly authorized by the board.

(v) Exercise all powers reasonably necessary to carry out the powers and duties granted or imposed under this chapter.

III. The entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance shall not:

(a) Purchase health care services, assume risk for the cost or provision of health care services, or otherwise contract with health care providers for the provision of health care services to enrollees.

(b) Exclude from membership in the alliance a small employer, eligible employee or eligible dependent of an eligible employee who agrees to pay fees for membership and the premium for health coverage through the alliance and who abides by the bylaws and rules of the alliance.

(c) Prohibit the participation of small employers, or differentiate classes of membership, based on industry type, experience, gender, family status, education, health status, income, or other means in conflict with the rating methodology specified in RSA 420-G:4.

(d) Charge a fee not directly related to the operation of the alliance or for non-health coverage related activities.

(e) As a condition of membership, require a small employer, eligible employee, or eligible dependent to subscribe to limited health coverage or non-health coverage related products or services.

(f) Operate the alliance or market the alliance in a county or primary urban statistical area in a way which would cause the alliance to select a risk pool with actuarially projected health care utilization over a 2-year period which is below the projected average for all individuals residing in that county or primary urban statistical area. The measurement and composition of projected utilization by members of the alliance to all individuals shall be done on a county or primary urban statistical area basis and not across all members of the alliance.

(g) Engage in any competitive act or practice that results in the selection of member small employers and enrollees based on any of the risk factors specified in this paragraph or based on small employer size.

(h) Require or take any action inconsistent or in conflict with state laws or regulations.

420-K:6 Requirements for Participating Carriers.

I. In order to qualify as a participating carrier, a carrier must be able to satisfactorily demonstrate all the following operating characteristics to the alliance:

(a) The carrier is licensed and in good standing with the department of insurance.

(b) The ability to administer health coverage, to provide adequate service, and to comply with all contractual requirements of the alliance.

(c) The ability to provide enrollees with reasonable access to covered services.

(d) The ability to provide coverage for enrollees in any regional service area in which the carrier plans to participate through the alliance.

(e) The ability to arrange and pay for the appropriate quality, level, and type of health care services.

(f) The ability to provide standard data required by the alliance, in a manner prescribed by the alliance, including information on plan performance, enrollee satisfaction, provider payment and incentive structures, and such other standard surveys as may be prescribed by the alliance, and to meet reasonable satisfaction measures as may be established by the alliance.

(g) The ability to meet quality of care standards established by government and industry authorities.

(h) A strong financial condition.

(i) Adequate administrative management.

(j) A procedure to address enrollee grievances and appeals.

(k) The ability to achieve satisfactory enrollment levels within the service area in which the carrier is licensed.

(l) All other criteria established by the alliance.

II. In evaluating which carriers may participate in the alliance, the alliance shall consider, among other factors:

(a) Minimum geographic service area and participation requirements, maximum thresholds for premium rates, and standards for determining whether a carrier operates efficiently.

(b) The ability of a carrier to provide high quality services within a regional service area.

(c) Pricing and the competitiveness of each bid from a carrier.

(d) The effect of contracting with additional carriers on the administrative costs of the alliance and member small employers, the efficiency of the alliance, and the competitiveness of the premiums that will be paid to participating carriers.

III. Participating carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the alliance, in consultation with the carrier's licensing agency:

(a) Review the quality of care covered.

(b) Review the appropriateness of care covered.

(c) Provide accessible health care services.

IV. Every participating carrier shall:

(a) Meet the standards established by the alliance pursuant to this chapter.

(b) Provide data and information as required by the alliance.

(c) Comply with all laws and regulations regarding underwriting, rating, claims handling, sales, solicitation, licensing, fair marketing, unfair trade practices, the provisions of this chapter, and other applicable state statutes.

(d) Enroll and dis-enroll individuals in the manner specified by the alliance.

(e) Comply with other requirements established by the alliance pursuant to this chapter.

V. Nothing in this chapter shall prohibit participating carriers from contracting with particular health care providers or types, classes, or categories of health care providers, or setting reimbursement methodology.

VI. Notwithstanding anything to the contrary in RSA 420-G:6, in the event the participating carrier elects to terminate its contract with the alliance, the participating carrier shall:

(a) Provide advance notice of its decision to the alliance; and

(b) Provide notice of the decision at least 180 days prior to the nonrenewal of health coverage to the member small employers and employee enrollees. A participating carrier that elects not to renew a health benefit plan with the alliance shall be prohibited from writing new business through the alliance for a period of 3 years from the date of the notice to the alliance or until the alliance, with the concurrence of the commissioner invites the former participating carrier to renew participation, whichever is sooner.

420-K:7 Marketing Health Benefit Plans.

I. The alliance shall establish marketing standards for use by participating carriers.

II. Any marketing, advertisement, or educational material for health coverage sold through the alliance shall be approved by the alliance prior to its use. The alliance shall review all materials submitted to it and the materials shall be deemed approved if not disapproved within 30 days. The alliance may, through its contracts with participating carriers, deem certain classes of materials to be approved.

III. The alliance shall make approved marketing materials available to member small employers in an efficient and standardized manner. These materials shall include, but not be limited to, an accurate summary of benefit plans, rates, cost, and accreditation information relating to the offerings of the participating carrier.

IV. This section shall not be construed to prohibit or to compel the alliance or a participating carrier from using the services of an agent or broker.

V. A participating carrier, agent, broker, contractor, or producer of a participating carrier, or independent insurance agent, broker, contractor, or producer shall not engage, directly or indirectly, in an activity or marketing practice that would encourage member small employers or eligible employees to:

(a) Refrain from enrolling in a health benefit plan offered through the alliance because of their health status or claims experience;

(b) Seek coverage from other participating carriers because of their health status or claims experience; or

(c) Enroll or fail to enroll in the alliance because of their health status or claims experience.

VI. Alliance members shall be encouraged to notify the commissioner of marketing practices or materials that are contrary to the provisions of this section. The commissioner shall monitor compliance with this section and investigate possible violations of the provisions of this section or other related unfair trade practices.

420-K:8 Risk Adjustment Mechanism. In order to reduce the incentive for risk selection and to improve fairness and efficiency, and in the absence of a risk adjustment mechanism established by regulation or order for the entire small group market, the alliance may establish a payment mechanism to adjust payments to participating carriers prospectively or retrospectively based on the amount of risk covered by each participating carrier. To establish such a mechanism, the alliance may appoint an advisory committee composed of individuals that have risk adjustment and actuarial expertise to help establish the risk adjusters.

420-K:9 Conflict of Interest. No officer or board member or director or contract administrator of the entity selected by the commissioner to assume administrative and fiscal responsibility for operation of the alliance or members of their households may be employed by, be a consultant for, be a member of the board of directors of, or be affiliated with, an agent of, or otherwise be a representative of a carrier or other insurer, a health care provider or agent or broker. This provision

shall not preclude an officer or board member or director or contract administrator of the entity selected by the oversight board to assume administrative and fiscal responsibility for operation of the alliance from purchasing health coverage through the alliance.

420-K:10 Purchasing Alliance Distinguished From Multiple Employer Welfare Arrangement. The alliance shall not bear risk therefore, pursuant to RSA 415-E:2, II, shall not be subject to the requirements of RSA 415-E.

420-K:11 Minimum Participation Requirements. The provisions of RSA 420-G:9 permitting carriers to impose minimum participation requirements on small employer groups shall not be applicable to the alliance or to member small employers, and health carriers may not impose minimum participation requirements, either on an employer-by-employer basis or as a percentage of all alliance enrollees, as a condition of becoming a participating carrier.

420-K:12 Purchasing Alliance Evaluation. The alliance shall make a report not later than January 1, 2001 to the governor, the commissioner of insurance, and the presiding officers of the legislature which shall include at least the following:

I. The progress achieved in making affordable health care coverage available to employees of member small employers.

II. The progress achieved in assuring choice of health carriers and health care coverage to employees of member small employers.

III. The need, if any, for financial incentives or other mechanisms to increase participation in the alliance.

IV. Other changes in the law or procedure needed to accomplish the goals set out in RSA 420-K:1.

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

CHAPTER 2

SB 162 - FINAL VERSION

5/13/99 1194s

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2000 SESSION

99-0601

01/09

SENATE BILL ***162***

AN ACT authorizing licensure and regulatory oversight of voluntary small employer health insurance purchasing alliances.

SPONSORS: Sen. Fraser, Dist 4; Sen. Trombly, Dist 7

COMMITTEE: Insurance

AMENDED ANALYSIS

This bill authorizes the insurance department to set standards for the licensure and regulatory oversight of voluntary small employer purchasing alliances.

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.

5/13/99 1194s

5jan00.....2182h

99-0601

01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand

AN ACT authorizing licensure and regulatory oversight of voluntary small employer health insurance purchasing alliances.

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

2:1 New Paragraph; Definition Added; Purchasing Alliance. Amend RSA 420-G:2 by inserting after

paragraph XIV the following new paragraph:

XIV-a. "Purchasing alliance" means a non-risk bearing corporation or other entity licensed pursuant to RSA 420-G:10-a that provides, on a voluntary basis, health insurance coverage through multipl unaffiliated participating carriers to member small employers and their employees within a defined service area authorized by the commissioner.

2:2 New Section; Voluntary Small Employer Health Insurance Purchasing Alliances. Amend RSA 420- by inserting after section 10 the following new section:

420-G:10-a Voluntary Small Employer Health Insurance Purchasing Alliances; Rulemaking.

I. The commissioner shall have the regulatory oversight authority to set standards for the licensure and conduct of purchasing alliances authorized under this section and to enforce such standards.

II. Each applicant and each duly licensed purchasing alliance shall file with the commissioner such information or documents as the commissioner shall adopt by rule as necessary to perform oversight function.

III. A purchasing alliance shall offer health benefit plans and establish conditions of participation for small employers, employees, and participating carriers that conform to the requirements of this chapter.

IV. Nothing in this section shall require 2 or more small employers to join a purchasing alliance as a condition of jointly purchasing health insurance coverage. Any such coverage jointly purchased by 2 or more small employers who do not join a purchasing alliance shall conform to the requirements of this chapter.

V. The commissioner shall adopt such rules, under RSA 541-A, and issue such orders as may b necessary to carry out the commissioner's oversight responsibilities under this section.

2:3 Repeal. The following are repealed:

I. RSA 420-G:2, XIV-a, relative to a definition of "purchasing alliance".

II. RSA 420-G:10-a, relative to voluntary small employer health insurance purchasing alliances.

2:4 Contingency. If during the month of January, 2006, the commissioner of insurance certifies to the secretary of state that no entity has been licensed as an alliance pursuant to the provisions of this act and is actively offering coverage and enrolling employees of member small employers, then section 3 of this act shall take effect on the date of certification. If no such certification occurs during the month of January, 2006, section 3 of this act shall not take effect.

2:5 Effective Date.

I. Section 3 of this act shall take effect as provided in section 4 of this act.

II. The remainder of this act shall take effect January 1, 2001.

(Approved: February 2, 2000)

(Effective Date: I. Section 3 shall take effect as provided in section 4.

II. Remainder shall take effect January 1, 2001)

Committee Minutes

Date: April 12, 1999
Time: 8:50AM
Room: LOB Rooms 206-208

The Senate Committee on **Insurance** held a hearing on the following:

SB162 *establishing the voluntary small employer health insurance purchasing alliance.*

(New Title) providing for the licensure and regulatory oversight of voluntary small employer health insurance purchasing alliances.

Members of Committee present:

Senator Wheeler
Senator Fraser
Senator Hollingworth
Sen. J. King
Sen. McCarley
Senator Squires

The Chair, Senator **Katie Wheeler**, opened the hearing.

Senator Katherine W. Wheeler, D. 21:
I'll call the hearing on SB162 to order and announce that I have an uncontrollable watering eye and I've made an appointment with my ophthalmologist and I'm not really that unhappy. It has nothing to do with the way I feel I'm just apologizing for the way I look. But we are very glad to have the Governor here and welcome.

The Honorable Governor Jeanne Sheehan:
Thank you Madame Chair, Members of the Committee it's nice to be in the same shell race and I'm glad it wasn't something I said. I'm pleased to be here in support of Senate Bill 162. As most of you know I believe Senate Bill 162 will allow small business to group together to form purchasing alliances to purchase health insurance.

(Governor Shaheen continues)

This is really a bill that was, is revised from a bill that was intruded into the legislature last session. I think this is the new and improved version. The bill last session was sent to a study committee. The study committee, some of you served on, worked very hard and recommended that we pass this legislation and set-up small business purchasing alliances.

This is really a continuation of a number of the reforms that this legislature has passed in recent years. Beginning in 1994 with Senate Bill 711, which set-up small group reforms in the insurance market. In 1996 passed legislation that made it exclusive contracts on health maintenance organizations. Both of those pieces of legislation really designed to better have access and affordability for people in this State for health insurance.

I think Senate Bill 162 is another effort to do that. Much of, there's a real need I think for this legislation for two reasons right now. First of all this bill is really aimed at small businesses. And as we know small business's really provide the backbone of New Hampshire, 98% of our business's employee 100 or fewer people. Much of the rejuvenation of the New Hampshire economy in this decade has been because of the new small business's that have been grown. Much of the new employee growth has been in those small businesses.

One of the difficulties that people, we've heard by small business, have is in getting health insurance. In fact as we look as what's happened in the economy as a whole in the last 5 years or so, the number of people without health insurance has been going down rather than going up. And that's in large part do to the fact that much of the employee growth has been in small business. And those small businesses by the fear of nature have had a much greater time in offering health insurance to their employee's.

The other reason that this legislation is particularly timely right now is because with the reforms that have been passed and the growth in HMO's and Managed Care coverage in the State, has been very effective in the past several years in keeping the cost of health insurance down. We're beginning to see that change right now. And in fact many businesses in the State are seeing fairly dramatic increases in the cost of their insurance premiums.

What this small business purchasing alliance legislation would do would be allow those businesses to get together to purchase health care at a cost that would be more affordable.

(Governor Sheehan continues)

One of the interesting pieces of information, as I was doing some background reading over the weekend on this, is looking at some of the States that have formed effective alliances and seeing what the benefits in those States have been. California's experience for example, looking at one of there health purchasing alliances showed that one of the reasons they've been able to keep the cost down is because they can administer the cost of the health insurance premiums so much more cost effectively.

What they found, in California, with this purchasing alliance was that the cost averaged only about 3% to 10% for administration. Where as if you looked at the health insurance market as a whole the cost of administering plans with fewer than 50 employee's averaged anywhere from 25 to 40%. So, one of the significant saving that happens because of these purchasing alliances is that they can administer the plans much more effectively.

One of the other benefits to the purchasing alliance is that, because of their bargaining power in the marketplace, they can provide more plan options for employees. So that as we see most employers can only offer 1 and sometimes maybe 2 plans to their employees. With purchasing alliances they can make more options available to the employees within the plans.

One of the other side benefits of purchasing alliances is that they can very often help mediate disputes between employers and health plans, which has proved to be very effective. So that they serve almost as an umbersman for issues that arise from businesses. Now, I'm sure as with many of the other efforts to reform or make changes in the health insurance market, we're going to hear from people who think this would be costly, who have concerns about how this would work, who think that this is another bureaucracy. In fact it's none of those.

This will be an opportunity for private entities; the government would not be involved except to the extent of the legislation to allow the alliances to operate and the Insurance Department would be involved with great relation. I think, what options we have as a State to continue to increase access and affordability in health care. This is one of the tremendous opportunities that we have. I would urge the committee to support the legislation and allow us to give the marketplace as many options as possible to deal with price and choice issues that consumer's have.

Thank you very much Madame Chair and I would be happy to answer any questions.

Senator Katherine W. Wheeler, D. 21:
Thank you very much Governor. Are there any questions for Governor Sheehan? See none. Thank you very much. I will call on the prime sponsor Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Good Morning Madame Chair, Members of the Committee for the record I'm Senator Leo Fraser, I represent Senate District 4. I do have some prepared comments to make but before in doing so I just wanted to thank the Governor for appearing here in support of 162.

(See attached written testimony, Document #1).

That's my direct testimony Madame Chair before I; I will just tell you a few technical aspects of the bill and several people here that know a lot more of the bill after you hear from them then than you will from me. But at any rate you should understand this is a non-profit alliance regulated by the Insurance Department. The Commissioner will approve of rates and it's going to be a statewide program. There will be criteria, for qualification, to become a member of the alliance; those qualifications will be established by the Department.

The Department will also be responsible for the standardized health plan. The alliance itself will be the policyholder. The duties of the participating carrier are all in the bill. In other words what their dues and responsibilities are as far as record keeping, financial statements all of that. It's a rather lengthy bill, Madame Chair, I don't seem to over simplify it but I think, to put it in perspective, this is a good idea. I think that it will probable help the small employers and giving them a more, as the Governor suggested, an opportunity, more choices in optioning a health delivery system number one.

Secondly that I think that under the terms of the; the bill is currently written there maybe times when a small employer will be able to afford insurance, health insurance he hasn't been able to do so in the past. That concludes my testimony Madame Chair, I would be glad to answer any questions but as you now there are a number of people here, who have a lot more technical expertise on this, then do I.

Senator Katherine W. Wheeler, D. 21:
Thank you Senator Fraser. Are there any questions for Senator Fraser? See none, thank you very much. Alex Feldvebel would you like to explain the bill a little?

Alex Feldvebel - New Hampshire Insurance Department:
Sure, I would be happy to. Thank you Madame Chairman my name is Alex Feldvebel I represent the Insurance Department. We're here today to support this legislation. We were involved in the drafting of it. What I'd like to do is just take a couple of minutes to talk about the reasons why it's needed, what it tries to do and then I'd like to hand out some materials that sort of talk about the structure of the bill.
(See attached Documents #2 and #2a).

The basic reason for this bill is to address certain problem today the health insurance market operates. So it's similar to the "711" reforms that we passed a couple of years back. Let me; just mention briefly, some of the problems with the health insurance market that we think are addressed by this legislation. One of the most compelling issues is the issue Senator Fraser already mentioned to you, the consolidation of the market on the supply side.

Both insurers and providers continue to consolidate their market power and you see the market heading in the direction of "oligopoly of power" on the supply side. So, for health insurer's it's been mostly consolidating, mergers and acquisitions. We also have market departures, so for example in the smaller group market, we're down to 5 HMO's with alliance share of the market going to 3 of them.

Health care providers, what's been happening, is that Hospitals and Doctors have been busy forming members and PHO's and Mega-PHO's (PHO – Physician/Hospital Organization). For the same reason, basically to get bigger, everybody wants to get bigger. For the Hospitals and Doctors that's for the purpose of getting a better negotiating position with the large MCO's. (Managed Care Organization).

At the same time employers that from the purchaser's side of the employers market position is eroding. At the National level now, private employers pay for just 21.2% of the Nations total health care spent. That was a surprise to me when I first read that. We think of ourselves as having an employer based health care system but there's been continuing erosion in that.

Government now pays 47% of all health care spending and individuals pay more than employers, individuals pay 26%. So, 4 out of every 5 dollars spent on health care is individuals or government. So you've got a situation now where health insurers are the final power because their bigger and fewer. And health care providers are more powerful because of their hiring network.

(Alex Feldvebel continues)

Market healthcare services continue to go up as well as utilization. Therefore market forces are not very well aligned with consumers and purchaser interests. And consumers and purchasers are likely to be paying the line; we see that happening now with significant increases in the cost of health insurance. This year the increases are, in the first quarter of this year to be 35%.

Other problems with the market, consumer choice is in the middle. I recently heard a figure that nationally 60% of people with employers sponsored health insurance have no choice of health coverage. In a small group market, for small employers it's much worse, 80% of small employer's offer only 1 plan, of those who do offer coverage and only 40% offer coverage. So there's no choice. That's not good for the market if you want competition the end user, the consumer needs to have a choice.

In addition consumers don't have very good information. Even though they do have a choice they can't exercise that choice meaningfully because they don't have good information about what the plan is, what's covered. Because the products are pretty, are sometimes pretty inscrutable. So we have these things going on all of which would be addressed by the formation of a purchasing alliance for small employers.

I would like to at this point, handout some materials. So, basically this small employer purchasing alliance is intent to address this issue of imbalance in market power by letting the small employer's get together, for the purpose of purchasing as a unit and increasing their bargaining power.

I will ask you to look at this first one, it says SB162 on it, ***(Handout, see attached Document #2)*** and also to offer choice. Those are the 2 basic reasons for the formation of purchasing alliance. The basic structure is this little picture on the front. Multiple employers get together through the single entity of the purchasing alliance, which turns around and contracts, with multiple plans.

Here are the basic functions of an alliance, on the second page it list them. ***(See Page 2 of attached Document #2).***
The alliance, once it's formed, turns around and negotiates and contracts with multiple insurers. They do the Marketing of the coverage, Enrollment, Premium collection and distribution. They supply Consumers with information about the health plans. They do the Data analysis to supply the consumer with information. They also pay attention to quality and they do plan performance measurement and Quality improvement.

(Alex Feldvebel continues)

That's the basic functions the alliance performs. There are a number of things that they don't do that distinguishes from MEWA's and other entities that have existed and also looked like group purchasing.
(See Page 2 of attached Document #2)

They don't bear risk, so they buy fully insured products. They're not a self-insured entity; they don't directly pay health care providers. So they're not like an insurance company themselves. They don't market for just one carrier; they don't directly provide healthcare services.

There's an analysis in the materials I gave you which, precisely how purchasing alliances go about conferring their benefits that we're planning on. One benefit is lower costs. And there are basically 2 mechanisms beginning, bargaining on behalf of large groups for producing more group bargaining power. And also when you perform these functions of marketing enrollment, payment collection and distribution for a large group you achieve certain economies of scale and therefore can reduce the cost of coverage in that manner as well.

You offer choice simply by marketing, by contracting with more than one plan and then providing good information for "apples to apples" comparisons and you also ask the carriers to offer their benefits in a standardized format. So, you define, like the 3 or 4 most popular plans, coverage options and the carriers all offer their coverage according to that standardized format. So you end up being able to produce minimal marketing materials, that some of the purchasing alliances have used.

I'd like to get these back, but there's one from Colorado, California and Connecticut. They basically layout a pretty easy to read format of what the options for coverage are. And you can easily comparison shop for price and quality. So the basic idea is to get insurer's peak based on value and not such things as risk selection. We don't want insurer's competing on who can get the healthiest groups. We want them competing on who can offer the best product at the best price.

And by bringing employers together and setting up the purposing through mechanisms like that, what you get is competition based on value. You also enhance quality because quality becomes more of a factor to the consumer. Because the consumer has choice and the consumer is well informed as to what he or she is buying.

(Alex Feldvebel continues)

I wanted to mention that there's sort of an outstanding issue about the way this legislation should be structured. This came up over the summer in the study committee and was discussed last year. The question is whether the legislation ought to allow for more than one purchasing alliance in this State. And I think it's very possible that it would be a good idea to do that. And I just wanted to let you know that that issue has been out there. That the legislation could be, that you have before you, contemplates "one person alliance" only.

The reason for going for a one-person alliance is you want to get bargaining powers, in a small State like New Hampshire you may have one small employer purchasing alliance. The, I think, would is there to recommend multiplies? Well in a situation when the State is not it's self putting up the money for the start-up cost for this organization, which we're not planning to do in this legislation, I think it could make sense to allow for more than one.

And have the oversight function of the Insurance Department be in the form of certifying these things. So any group that meets the right qualifications in the Legislation can come forward, ask for certification and if they are deemed to meet the requirements they'll get certified.

So I think there is some sense to that and that's an issue that's still outstanding. The Insurance Department would be happy to work with the Committee if you felt it was a good idea to change the Legislation to allow more than one purchasing alliance. That could be done relatively easily. The Legislation you have before you is based on a NAIC model. There is more than one model. One of the other models is this concept I have just been talking about that would allow more than one small employer purchasing alliance in this State. I'd be happy to answer any questions.

Senator Katherine W. Wheeler, D. 21:
Any questions? Senator Squires.

Senator James W. Squires, D. 12:
I have a question about you're statement that 4 out of 5 healthcare dollars are spent by Government and individuals. Would you not agree that while that may be true for a Nation as a whole, you look at the population being served by an environment like this, which would be non-Medicaid working people up to 65. That there's a much higher fraction of employer contribution in that group then there maybe nationwide?

Alex Feldvebel:
Oh, yes. This Legislation is aimed at employer sponsored health insurance coverage. The only point I'm making in siting that statistic is that there is; employers need help there's been an erosion that the market forces have been pushing, have been really squeezing the whole institution of employer sponsored coverage. And it's in danger of getting too weak that's the only reason I'm making that point.

Senator James W. Squires, D. 12:
So then it's your assertion that the heart of this bill reduces the cost to employers?

Alex Feldvebel:
It makes it easier for small employers to offer coverage. They are not in good position to contract nor negotiate like large employers. It through greater bargaining power it offers a price advantage, not necessarily a great pricing advantage, but a marginal, comparable price advantage.
(Alex Feldvebel continues)

And allows the small employer to offer choices, something almost no small employers can now manage at this point and time. So, somewhat of a price advantage, offering choice and a lot less hassle to the small employer in offering a reduced sign-up.

Senator James W. Squires, D. 12:
Would you agree that in certain parts in the State, particularly to the north, why you may conceivably offer coverage choice, the fact is it's difficult to offer provider choice because there's a very limited number of providers in the first place? So, in fact that's somewhat to New Hampshire that even though you have multiple plans you have fixed number of providers? So you're not in fact offering provider choice your simply offering more of a plan choice?

(Tape Change)

Alex Feldvebel:
So any plan choice couldn't give you provider choices that you won't otherwise have.

Senator Katherine W. Wheeler, D. 21:
Further questions Senator Squires?

Senator James W. Squires, D. 12:
No thank you.

Senator Katherine W. Wheeler, D. 21:
Further questions from the Committee for Mr. Feldvebel? Senator McCarley.

Senator Caroline McCarley, D. 6:
In terms of the concept they adopt the fact that it would be possible to have several alliances rather than simply one? In a State of this size is that a, do I assume that this model will show that because that doesn't seem to be quite the same kind in the State of our size?

Alex Feldvebel:
Right. You need a certain size to make these alliances able to deliver the benefits that we're talking about. It would be like 20,000 (someone from the audience states 20,000 is the critical threshold), maybe less but you need, that's fairly a significant number and it would be hard for to have. Multiple alliances are able to get that kind of enrollment. On the other hand if you let anyone who meets the qualifications give it a shot maybe you'll have a better chance at having one of them succeed. So that's sort of the thinking of allowing for multiplies.

Senator Katherine W. Wheeler, D. 21:
Senator Hollingworth.

Senator Beverly A. Hollingworth, D. 23:
Alex, last year there was sort of, the Senate passed it and I know the House had some problems and it was, it seemed that some the argument that they had against it was they were afraid that it would cut into they're market. Now there is no exclusion is there so that, if somebody offered a good plan, one that has choices and one that's within the market, price market, would there be no reason why they couldn't be in involved in the alliances, is there?

Alex Feldvebel:
Yeah. Who's the they?

Senator Beverly A. Hollingworth, D. 23:
There were a couple who came before us and testified, HMO's and the insurance groupies that came in. I could never understand and I guess I'm asking you to help me understand why they would oppose this if they write for this can't they? We aren't excluding anybody from being involved in and being selected if they the right choice and the right price?

Alex Feldvebel:
The reason for the Legislation is that the alliances are suppose to offer as much choice as possible. So it should contract with a large array of plans to offer as much choice as possible. Yet the companies that expressed concern I don't think, it hasn't been expressed to me that there're concerned about being closed off. We have a lot of the good quality carriers in the State. What was expressed to me was fear that the way they market now, they basically sell to the employer and they get the whole group.
(Alex Feldvebel continues)

If the alliance exists like this they wouldn't necessarily get the whole group. They might get some of the people. There's a group of small employers say 10 people they might get 3 and they prefer to get the whole group, they prefer to deal with the employer not the employees. That's one perspective up north the consumer's need to have choice and they don't get very much weight.

Senator Beverly A. Hollingworth, D. 23:
Follow-up question. Can they then pick companies who have healthy employees, rather than wait for all small groups were involved? Say you might have one that has older employee's or young women who maybe pregnant so that they can say we're going to select this company because it's what we know to be a good, almost like a "cherry" type group?

Alex Feldvebel:
I believe that still goes on to a certain extent. We address a lot of the risk selection with the "711" reform with regards to rating health, health underwriting, health based underwriting. But you can do risk selection in this market. You do it mostly through benefit design. So you structure your benefits so it looks less attractive to say people more affected health people. More through marketing, the way that you market.

(Alex Feldvebel continues)

You can emphasis healthy people. So there's a lot of evidence that that kind of risk selection still does go on through those two mechanisms plan design and marketing. And the existence of a purchasing alliance will help prevent that and also if the person wants to exercise the option to adjust their risk and therefore compensation the plans that aren't giving risk selection and getting more sick people. It sort of eliminates that market incentive to risk select and what (inaudible) gets is competition based on value.

Senator Katherine W. Wheeler, D. 21:
Thank you. Senator King.

Senator John A. King, D. 18:
What is the dedication of the, either the companies that are going to be involved or the health agencies. Can the leave anytime they want? Can they change from one to the other in same lines, what is there for stability as far as that's concerned?

Alex Feldvebel:
The companies?

Senator John A. King, D. 18:
The companies and the employees that are going to be involved and the employers, can they back out at anytime they want to?

Alex Feldvebel:
The companies can back, they have to give certain notice, I think it might be 90 days before the back out. Then, I don't know, if they want to come back in I don't know if the Legislation address that issue or not. Employers can back out as well. There is some provision in the Legislation about if they backed out can they immediately get back in? And there's an issue there as well but I'm not sure. That's something I need to address with an amendment because the Legislation currently allows, says if an employers back out they may have to have a waiting period before they can come back in. I'm not sure that's consistent with our guarantee issue law. So that's something we still need to pay attention to. So there are certain restrictions but basically an employer can come in or back out and the plans can come in and back out.

Senator Katherine W. Wheeler, D. 21:
Senator King.

Senator John A. King, D. 18:
So it's all voluntary? That's even for the companies? If they don't want to join up and end up with an alliance there's no cost?

Alex Feldvebel:
Yes. You can start one of these things and the company could boycott it. They could say "we don't like this kind of thing" and we don't want to let it happen. That's been attempted in other States and generally they seem to, if they are setup properly they seem to work. The companies don't want to miss the opportunity of that business.

Senator Katherine W. Wheeler, D. 21:
Any further questions for Alex Feldvebel? See none, thank you very much. I'm going to call on John Bresler now and then I'm going to start alternating testimony.

John Bresler – Suncook Trim Corporation:
Thank you Madame Chair I appreciate the opportunity to speak early. As I look around the room I may be the only employer here and I sit here and discuss this bill the question in my mind is who's watching the store so I would like to get back to work. I came before the Committee last year but I didn't get the chance to speak because I had to leave after a couple of hours, so once again thank you.

I want to thank Senator Fraser. In his district is Pittsfield Weaving, I run a similar business in Suncook. I also wanted to thank Senator Trombly, who I spoke to over the weekend, as co-sponsor. I said people do not realize that the health care cost is a bigger single increase. Therefore a bigger problem for our employees and our bottom-line many of the tax issues going through the State.

We recently did our purchasing processing. We had Harvard, Tufts, Matthew, and Healthsource, who was our supplier. The smallest increase we were able to limit our new contract to was 35%. Having roughly 50 employees and revenue slightly over 4 Million in 1998 I can tell you the cost of our health care in 1998 was 2 ½ of gross revenues.

(John Bresler continues)

And with the increase of, that was roughly $104,000.00 in checks that I wrote to Healthsource. And this year our bill came in, the lowest bill we could get was $139,000.00 for the same services. So once again that $35,000.00 increase is a lot more than the BET, the BPT and any other group of taxes that were coming up.

What I would like to simple lay out, it will take about 5 minutes, and I will finish this competitive model for business. 2.9% of unemployment the greatest need is to recruit, hire, train and retain good employees. It is basically impossible for us to retain high quality employees when benefits are the issue.

Over the last 4 or 5 years since NAFTA we have had the competitive nature of our business has changed. In a non-intuitive way in that we have seen many companies from outside the United States come in and open-up new businesses in our business. People from China, Columbia, Argentina, Iran basically with NAFTA, everybody recognized you have to be in Canada, Mexico, the United States to sell our markets which are deplored in the world.

Specifically we have competitors in New Brunswick in Eastern Canada that brought in firms from China. They currently pay an industrial rate. Canada pays for the health care, the current wages are about 20% less and with the Canadian dollar they can essentially ship-in freight prepaid at our manufacturing costs. So we certainly now what competition is and if we are the "Canary in the coal mine", I would suggest to you folks here that manufacturing is not a given.

So, we look at what is the contract between us and our employers. Essentially we feel that to provide at least catastrophic health care is something we must do. And in return for our risk and our possible reward we're going to make the money, they're going to do the work. They deserve to have the knowledge that they can have their kids and themselves covered.

Under the new increases, specifically, for some reason single moms are the ones who get hit. And there's a big cost to society there because the incentive for them is to go back on welfare to get the health care. So we see people struggling to have day to day, go to work, pay for their health care and their not asking for much.

(John Bresler continues)

So, I would say to you again, to follow what Senator Fraser said, it's a good idea. I think for many of the insurance companies, the argument that I hear, is somewhat circular. Which is it's a bad idea because it won't work because it's a bad idea. I think that if they felt their revenues would go up under this plan, they'd think it's a good idea.

It's not simply the insurance companies who are at fault certainly there's the whole issue of health care and the delivery of health care and the cost of health care. Let me just ask a question and I didn't see it in the bill. And that is, is there any sense that this is a high cost option for the State of New Hampshire? I don't think it is.

I think that in a "state of flux" certainly now as we know our tax structure is in a "state of flux". Anything that government can do to create a competitive advantage for small business who employs more than 50%, sometimes 75% of everyone in the country. Gives us the opportunity to higher, train and retain good employees by providing them the basic, simply health plans at a reasonable cost.

My final suggestion might be this and I'm not sure it makes sense to you in-light of the bill but I will offer to you. There is no suggestion that there is any cost to companies for being involved in the alliance. For my personal point of view there's a great benefit to spreading the risk of analysis the plans. And the "apples to apples" situation is the hardest for small companies.

It takes one fulltime person about 3 months to spreadsheet and understand the differences, the little hooks, that the varies company put in or things you didn't know was a trap door that you only find out later because you were focused on the cost. Your focused on trying to make a profit and you don't have the time to figure out this ones hospitalization is better than this ones but over here you get a better prescription plan. There's got be an economy of size in this alliance. I'm paying for people to do this fulltime.

If 4 or 5 companies could get together, there's defiantly a cost savings. And perhaps the businesses in the alliance could bare some percentage of the cost because they certainly get the benefit in either cost reduction and/or better benefits for their employers. That's basically my position and I very much appreciate the opportunity to share it with you.

Senator Katherine W. Wheeler, D. 21:
Any questions for Mr. Bresler? See none. Thank you very much for coming and testifying we appreciate your time. David Larrivee, from Tuft's Health Plan wishing to speak in opposition to the bill.

David Larrivee – Director of Market Relations, Tufts Health Plan:
(See attached written testimony, Document #3).

Senator Katherine W. Wheeler, D. 21:
Any questions for Mr. Larrivee? Yes, Senator Hollingworth.

Senator Beverly A. Hollingworth, D. 23:
Yes, Mr. Larrivee do you have a copy of your speech?

David Larrivee:
Yes I do and I would be happy to leave it.

Senator Katherine W. Wheeler, D. 21:
Further questions?

Senator Beverly A. Hollingworth, D. 23:
Yes. Do you write for any States or does your company write for any States?

David Larrivee:
To my knowledge Maine is the only one where there is a current Statute passed or actually in place.

Senator Katherine W. Wheeler, D. 21:
Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Mr. Larrivee first of all I totally disagree with you that this may not reduce cost. I don't know and I don't think you know either whether that's a fact or not. That's not a question that's a statement, I apologize for that. I will ask you a question.

(Senator Fraser continues)

I assume that if Senate Bill 162 is enacted and the Governor signs it that Tuft's Health Plan would not be one of the participating carriers? Is that a fair statement?

David Larrivee:
I think we'd need to evaluate the specifics of the Legislation that actually gets passed. There are certain components of this that make it very difficult I think for us to entertain participating, although we are committed to the small group market place. The small group market place makes up more than 80% of our total business in the State. That's the way the State operates, is the small employers as other people have mentioned. So we would want to be at the table as it relates to small employers, it's that that it's viable to us.

Senator Leo W. Fraser, Jr., D. 4:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Further questions? Senator King.

Senator John A. King, D. 18:
You said there was 89%?

David Larrivee:
In policies, I believe.

Senator John A. King, D. 18:
Where, what states we're they?

David Larrivee:
In this State, in the state since the small employer accomplishments there's been a dramatic increase in the number of policies, small group policies. I can tell you that just from a personal experience at Tufts Health Plan. We've seen over 5,000 new small employers with an average size of 2.

(David Larrivee continues)

Meaning a lot of small employers, some of them I think probable were in the individual market, have become part of the small group market because they are licensed businesses and because the current legislation allows us to offer a competitive package which they can compare, use brokers and agents to do so and to increase the best value for their dollar.

Senator Katherine W. Wheeler, D. 21:
Further questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Mr. Larrivee is it a fair statement that Tufts Health Plan vigorously opposed 711 when it was being legislated.

David Larrivee:
No, I believe actually we we're not in the State at the time. This was back in 1994; we were licensed in 1995. So we were not part of that.

Senator Leo W. Fraser, Jr., D. 4:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Any further questions? See none. Thank you very much. Karen Hicks has asked for a minute or two to be able to explain something.

Karen Hicks – Governor's office:
Thank you Madame Chair, I really only want to take one minute to address something Alex meant to speak too in his explanation but David also reminded me we need to address this.

One of the issues the opponents of this Legislation have raised is the whole idea of risk segmentation in the market. I want to say that, first of all that is obviously not the intent. The Governor is a strong proponent and protector of the small group and individual market reforms. And we really kept that in mind when drafting this Legislation. It is meant to take the next step that we started on when we enacted the reforms.

(Karen Hicks continues)

The alliance would have to play by the same rules as everybody else in terms of community rating, guarantee issue, all of those things. Which really apply to the insurance side of this. This enables small businesses to come together. It will not allow the purchasing alliance to prohibit any company that wants to from joining, so long as they adhere to the group size. So, I just want to get that out on the table right now, it's something people have raised over and over again. I just think the argument doesn't have any merit.

The second thing that I wanted to address is one of the issues that the Legislature thought was very important in the enactment of Senate Bill 711 in 1994 was the need to really increase the predictability of health insurance prices for small business. I think over the, certainly the Legislation helped to do that, but one of the things we've seen over the past 3 or 4 years is intense competition in the health insurance market. Where many companies purposely chose to under-price their product, write the product at a risk and now I think we're seeing, in the so-called market adjustment, them exacting their price for that under-pricing.

One of the things the health insurance purchasing alliance would do is even-out competition so that we don't have this phony competition. We don't have significant under-pricing only to have carriers get a significant share of the market and raise prices again. It will help keep downward, consistent pressure on premiums so that it's more predicable for small businesses. They need that level of assurance and predictability. So I just wanted to address those two issues. Thank you.

Senator Katherine W. Wheeler, D. 21:
Any questions for Karen Hicks? Senator Squires.

(Tape Change)

Senator James W. Squires, D. 12:
I just realized, until I read this report here. That if the alliance is going to define a set of standardized health benefit plan?

Karen Hicks:
Right.

Senator James W. Squires, D. 12:
Does that mean that the alliance will decide on a benefit plan, will decide if a benefit is covered or not covered?

Karen Hicks:
The alliance would come up with a standardized benefits package. The reason for that is so that companies can actually compare "apples to apples". And so there won't be just one benefit offered but rather, if it's functioning properly, you could have a minimum of 3 carriers offering as many as 9 different products. So the goal in that is to really facilitate comparison so that we have competition not only based on price but also based on value.

Obviously, because it's purchasers who would be driving the benefit selection rather than those offering it, I would assume they're really going to keep an eye on cost since they're footing the bill. The other compelling reason I think that's linked to that is one of the things Rick Curtis, who's a expert nationally on health and has put these things together. One of the issues that he spoke to that I think is very compelling is that this will stabilize coverage for the employees.

Since small businesses who are offered health insurance are so cost sensitive they're in and out of the market with very short turn around because of a 10 or 15 or 20% cost increase tips it over the edge. So one of the ways this helps to decrease the number of uninsured is allowing employers to offer a contribution. So if the baseline price for a product is $150.00 the employer can choose to pay only $130.00 and the employee can make up the remainder and have greater choice.

So if they want to choose up they can add their own dollars in and experience the benefit of that choice. Not only will it allow families to have one health plan where as right now both parents are employed by a small business they can be in as many as 2 or 3 health insurance plans. It will allow the families to stick together but also help to stabilize it. So that they're not being driven so much by the cost sensitivity but with they're own resources they can help provide some stability there on.

Senator James W. Squires, D. 12:
You think that you or the Insurance Department could obtain an example of this?

Karen Hicks:
Of the standardized benefit product?

Senator James W. Squires, D. 12:
Yes.

Karen Hicks:
Certainly.

Alex Feldvebel:
I think it's those booklets that are in your binder.

Senator James W. Squires, D. 12:
I guess I; just a follow-up. If there is such a concept if it's consistent, I'm not sure the Legislature couldn't require the Insurance Department to develop such a plan. And then make sure each carrier offers it among their other offers. I don't know why we would want to single out a new corporation to define a benefit plan. I understand it in an Indemnity setting that's sort of what Medicare does. There is a set of benefits and everybody has to live by them. But in a Managed Care setting a standardized set of benefits being offered by every plan is something I want to see.

Karen Hicks:
Senator Squires it is my understand that right now that many employers choose they're own benefits plan, this in this out, based on what the needs of they're employees are. And so what this would simply do is extend that to the Health Purchasing Alliance about the member employers to really have a lot of input into what those benefits packages look like. Rather than having the plans dictate, which they do for small businesses I don't think that small businesses currently have the market power or clout to really alter the benefits plans to the same extent their large employer/counterparts do. And so I think that again this is trying to provide some equity in the market between large and small employers.

Senator Beverly A. Hollingworth, D. 23:
(Senator Hollingworth has temporarily taken the chair)
Further questions for Karen Hicks? See none. Thank you. Bill Bartlett.

William Bartlett Jr. – S&H Murphy:
Good Morning Madame Chairman, Members of the Committee I'm William Bartlett from S&H Murphy we represent Harvard Pilgrim HealthCare. With due respect to the Governor we formally appear in opposition to SB162. I have a prepared statement by Tom Gough who is the Director of New Hampshire Operations and Development.

(See attached written testimony, Document #4).

Senator Beverly A. Hollingworth, D. 23:
Thank you. Any questions for Mr. Bartlett? See none, thank you.

Senator Katherine W. Wheeler, D. 21:
George Bald.

George Bald – Department of Resources and Economic Development:
Madame Chair, Members of the Committee, Good Morning my name is George Bald, Commissioner of the Department of Resources and Economic Development.

(See attached written testimony, Document #5).

Senator Katherine W. Wheeler, D. 21:
Any questions for Commissioner Bald? See none, thank you very much for coming. Harold Sullivan.

Harold Sullivan – NHALU:
Thank you Madame Chairperson, my name is Harold Sullivan I'm the Legislative Chairperson for the New Hampshire Association of Life Underwriters. We're approximately about a 600-member organization of agents and brokers producing life and health insurance in the State of New Hampshire.

In contrary to what the gentlemen said before many of our members are self employed individuals who do provide for their own employees. It effects us in 2 ways when this type of legislation comes in. As the Govern said this is Legislation that is very similar to SB494 which was proposed last year. Many of you know we opposed that bill and most of our concerns continue with this bill.

(Harold Sullivan continues)

The only significant improvement we see is that now this would be supervised by the Insurance Department rather than the Department of Health and Human Services, which is an improvement in the Legislation. However the rest of the concerns remain unchanged.

Our associates with the health underwriters will give a more specific testimony of our concerns so I won't duplicate their testimony. But I would just say that not much has changed since last June. I don't think the State of New Hampshire has grown any larger, not that large of an increase in population.

It's been shown in other States that these Purchasing Alliance work best in large States with significant pools to bring together so there is some economy of scale. I think you would need to involve the entire small market. Pulling the whole small group market into the alliance if you're going to work this alliance efficiently. As Senator Fraser said you haven't proved there's any increase in cost but we haven't proved there's any decrease in cost either. So our concern from last year remains unchanged. Thank you Madame Chair.

Senator Katherine W. Wheeler, D. 21:
Thank you. Any questions for Mr. Sullivan? See none thank you for coming. Jonathan Stuart.

Jonathan Stuart – North Country Health Consortium:
Good Morning, Madame Chair, Members of the Committee. I'm Jonathan Stuart I represent the North Country Health Consortium, which is a collaborate of 10 Health and Human Service Organizations providing health care services north of the Notches. I'm here today to speak in support of Senate Bill of 162. I have handed out a prepared statement and summary, which I will go through for you.

(See attached written testimony, Document #6)

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Any questions for Mr. Stewart? See none thank you for coming to testify. Lori Real.

Lori Real – Director of Planning and Research, DHHS:
(See attached written testimony, Document #7).

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Any questions for Ms. Real? Senator Squires.

Senator James W. Squires, D. 12:
Lori, your statement about choices certainly has to be true but I keep coming back to the cost question. And if you were to ask the question in a particular manner, does an employee want more choice and willing to pay for it them selves you might get a different answer.

My question is health care cost fundamentally; I relay it to the benefit structure, despite all of that about administration the fact remains that the driver in health care cost is the benefits.

So my question is why do we need an alliance to define a set of benefits? Why would it not be just as possible to say the Insurance Department who know more about benefits then seems to me a newly created alliance you will design a baseline set of benefits and compel every carrier in New Hampshire to offer it. Then you know whose claims are whose. What is the advantage of doing it this way?

Lori Real:
I think that the Department of Insurance is very capable of doing that but the New Hampshire way is less Government proposing and complying and mandating then it is involvement from the community and the employers. And that they employers participate in that development where they'll feel that they better understand what their employees needs are. Then they will be more likely to enter into a purchasing alliance than if it was mandated. I think it's that philosophical involvement.

Senator James W. Squires, D. 12:
That elusive New Hampshire way, thank you.

Senator Katherine W. Wheeler, D. 21:
Yes Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Lori would you agree with me that in all likely hood that using the same standardized product that in all likely hood an employer, a small employer with 50 employees goes to market, he in all would probable get a higher price for his product than if there's 5,000 members to insure? Is that a fair statement?

Lori Real:
People from the Insurance, I think, industry could speak better to that than I but my past experience on the insurance side of the market is that it does cost more administratively for small groups individually than it does for large groups.

Senator Katherine W. Wheeler, D. 21:
Any further questions? See none thank you very much. I have a card for people who do not wish to testify. Paula Rogers has signed up in opposition and has submitted written material. ***(Each Senator received their own letter).*** Katharine Eneguess has signed up in support, representing BIA not wishing to testify. Senator McCarley signed up supporting the bill not and not wishing to testify. Tom Harte wishing to testify in opposition.

Tom Harte – NHAHU:
Good Morning Madame Chairwomen, Committee Members my name is Tom Harte and I with Landmark Benefits Group in Salem New Hampshire. I have submitted written testimony, which I hope you have time to review. ***(See attached written testimony, Document #8).***

But instead of me reading from my testimony I will talk to you about a few points I've heard today that I wanted to provide verification for. The organization I represent today is New Hampshire Association of Independent Insurance Agents and also The New Hampshire Association of Health Underwriters.

The first thing I want to talk about is who is the broker? I've heard some people come up today and talk about different roles that the alliance would perform, different roles the Department of Insurance would perform. But I run a very small practice in Salem. We have one employee who represents maybe 20 small employers in the State of New Hampshire and thousands of our insured population.

(Tom Harte continues)

My job everyday is to go through those spreadsheets from that gentleman who comes from Suncook. My employer clients don't need someone working fulltime for 3 months to shop all the different benefit in the State of New Hampshire and all the plans that are within those companies.

My job is to do the people who work for me, that is our job to do that and in addition to the shopping that we do, as that gentleman referred to it, we take care of consumer complaints, everyday. That instead of going through the Department of Insurance, consumers advocate, we take care of that for them. Not only can we perform those tasks we take care of full Cobra compliance; we take care of take-over benefits. We insure that the provisions of the Federal Government are protected. We make sure that if the employer has questions regarding provisions we take care of them right there.

So instead of passing that over to the Health Insurance Purchasing Cooperative we would take of ourselves and for what a very, very, low fee. We are aloud to charge fees in our practice, but we do not charge fees, we solely take commissions from Health Insurance Companies. We take care of benefit education, marketing, we do the physician matching.

Before we even go into an employer, especially a small employee less than 10 employees, we go to the employees and ask them who your PCP? If you had a choice of a hospital to go to what hospital would that be? One of the best things that has happened over the past couple of years, since Tufts Health plan and Harvard and Blue Cross has improved their benefits in Mass, Mathew Thornton and other plans, we have access to Boston facilities.

We have excellent hospitals in the State of New Hampshire who have had person problems in members, where as there is a lack of coverage amongst the hospitals. So our insured population if they feel better about it have full access to Boston Hospitals where as prior to 1995 with the health plans that were in the State at that time, to be very difficult to do so.

Now I will talk about consumer choice. Last year in August, Legislation was passed that prevented any employer who had 3 employees to offer more than one health plan. There's a 37-½% requirement for employee participation and in the event a 3-person employee wanted to over 2 medical plans they can not do it. It's impossible to do it, you have 2 employees choice 1 health plan the other employee choices the other health plan, because their physician is in there, they can't do it, 33%.

(Tom Harte continues)

So, that's been a huge challenge for us in the past year. And in certain situations you have a 10 person employer and only 1 or 2 people want to have a Blue Cross policy and everyone else wants to have a Harvard plan, you can not do it, it's impossible. So, the Legislation historically has shown that employee choice is not a big a concern to Legislators as are other concerns.

But it's a concern for us, the Health Underwriters, the Life Underwriters, the Insurance Agents and our consumers, want to have that choice. Do we need to go to a Health Insurance Purchasing Cooperative to do so? I don't think so. I think that the repeal of the 37 ½% requirement is a huge step in the right direction to provide employee choice and consumer choice.

Even the State of New Hampshire, the State of New Hampshire in a recent decision to have their own medical plan the took one medical plan. They didn't have to choose they could have chose 2 or 3 or 4 medical plan that are insured in the State. They chose one; there is a reason for that, I can't tell you what the reason was.

But it kind of disturbs me that the State of New Hampshire in a purchasing made one health care decision for all their employees as opposed to just one. I know that members of the Department of Insurance don't appreciate that as well, they'd like to have some options.

The comparison between other States, Colorado, California and Connecticut and looking at the State of New Hampshire, New Hampshire is one of the healthiest States in the country. They also have the best medical insurance plans available to employers and consumers. If you look at, use Newsworld report back in October or Newsweek, I presented you with those articles; we have the absolute best health insurance plans. We have the best access to physicians, the healthiest State. So we can not compare the demographics or the characteristics of the State of New Hampshire to those 3 other States.

And if it works in those States does that necessarily mean that it's going to work in our State? I don't think so. It may, I don't know, it could. But that's the big question everybody is saying today, it might work but we're not sure. Nobody can give us any guarantees. One of the real interesting concepts I'm thinking about as I'm sitting back here is that the Department of Insurance and the Governor's office, I thank them very much for making a stand to include brokers and agents in this bill, because last year it was questionable, are brokers going to be considered in this bill? It changed earlier this year to include brokers and agents.

(Tom Harte continues)

And I'm still sitting here today, even though that I know that I can be paid and compensated for it and health plans know that they can possible increase their market penetration, but we are still opposing it. Not because I don't think that I'm going to get paid and that I'm going to be compensated fairly or that the health plan is going to increase their market share but rather because we think that it's not going to work.

That the Alliance is not a necessary component of the health care marketplace in the State of New Hampshire today. If I could make my life easier, I have 3 little kids; I want to be home with those kids as often as I possible can. If it makes my life easier it can make the lives better for my consumers and my clients I would love to do it.

But I don't think that the lack of employee choice as it stands today, there is a reason for the 30% rate increase that we've seen. I don't like to see it, I don't like going to my employers and saying, "here you go, here's a 35% rate increase". Those are other problems, those are other health problems that we have across the State, with the hospital competition and prescription cost increase of 16% over the past year. I think the individual health care is a larger concern than trying to focus on a Health Insurance Purchasing Cooperative.

The North Country, another gentleman brought that up, I think that's a problem. But Tufts, Harvard Pilgrim....*(Tape Change)...end of testimony.*

Senator Katherine W. Wheeler, D. 21:
Thank you, any questions? Senator Hollingworth

Senator Beverly A. Hollingworth, D. 23:
You said you could charge fees for your services but you don't you take the cost from....., I didn't hear what you said. How do you...?

Tom Harte:
I solely get compensated from the health plans.

Senator Beverly A. Hollingworth, D. 23:
So the health care plans they increase their cost so that they can provide to re-coop they salary.....

Tom Harte:
That's not necessarily true. Health care plans today when they file their rates with the Department of Insurance include a component of compensation for brokers and agents.

Senator Beverly A. Hollingworth, D. 23:
But that does in fact, the cost, include the cost delivering health care?

Tom Harte:
It does, but under the HCPC plan the same rules also apply.

Senator Beverly A. Hollingworth, D. 23:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Any further questions? Senator Squires.

Senator James W. Squires, D. 12:
The testimony before, the individual who I think ran a manufacturing firm, alluded to the necessity to clean the house as it were to exam all these plans. But what prevents him from hiring you, or somebody to do that for him?

Tom Harte:
Excellent question. As I said before I have a very small practice and our clients really appreciate the work we do for them. Most of our clients don't go out to bill to all other health insurance brokers through the course of the year because we do a really good job for our clients. I think for that gentleman, if I could had him a business card and say my name is Tom Harte from Landmark Benefits I can save you time, we can do that job for him he just needs to find the right person to do that.

Senator Katherine W. Wheeler, D. 21:
Further questions? Senator King.

Senator John A. King, D. 18:
If it's not mandatory you don't even have to participate, why all the concern?

Tom Harte:
Why am I alarmed? Well I first say the bill last year, when it was in the House of Representative, I thought that it was an interesting concept. I also thought it was interesting because it would offer for multiple HCPC's. So that my company could actually start there own HCPC's and go to Tufts Health and Harvard and Blue Cross.

But then I looked into it further and I said "well right now we are in guarantee issue State" and we're community rated across the board. In the event that we were to pull from the million dollar pool of individuals, let's just say 30,000 people, how would that adversely effect the rates in a community rated pool?

Insurance works on being able to determine the risk. The greater the pool the better the insurance companies get to determine that risk. You pull those 30,000 people out then that would adversely effect their ability to calculate the risk across the board.

So that was my first concern, the other concerns that I have are related to "is it really cost effective for the State of New Hampshire to" and I am not an expert in policy I'm only an expert in consumers, I deal with them every single day. Is it cost effect for them to setup a new system a Health Insurance Purchasing Cooperative, duplicating what I do everyday and duplicating what the health care plans do everyday? Does that answer your question?

Senator John A. King, D. 18:
I gather from your testimony you look at the whole picture?

Tom Harte:
Yes.

Senator John A. King, D. 18:
Is it a better thing for the people; the small companies of New Hampshire or isn't a better thing? Everybody, companies can join this, insurance companies can join this. They all take that risk one way or another.

Tom Harte:
I don't think that the State of New Hampshire needs to set up the lengths that they are looking at for a Cooperative to be able to do that. I think that a simple solution such as a bill dealing with the 37 ½% requirement, to go back to allowing me to offer choice to my employees.

Senator Katherine W. Wheeler, D. 21:
Questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
I ask this question of the last speaker, would you agree with me, in your capacity as a consultant, that in all likely hood that if you had employer with, who wanted 50 life's insured versus an employer that wanted 5,000 life's insured that in all likely hood you'd be able to better price per life for that 5,000 block of business versus the 50 live block of business? Is that a fair statement?

Tom Harte:
I don't claim to be an expert in actuarial sciences but what I do know is that we have a lot of employer clients in New Hampshire and through out New England and New York, that are larger clients that may at times, and I don't the percentage but it's pretty well balanced, at a higher price per capita then our smaller employer clients. All of my smaller employers might be a younger group with an average age of 30-35 years of age. Where as an established employer, a larger employer, have an older practice. So, by having a 5,000-group pool doesn't necessarily help my small company.

Senator Leo W. Fraser, Jr., D. 4:
I guess maybe it's not a fair question. But if you had the same, you could offer the same product, it seems to me in my experience would you believe, that someone goes to market with an offer to insurance 5,000 life's in all likely hood there going to get a better price than someone goes to market trying to insure 50 life's, using the same product.

Tom Harte:
Exactly. If your questions is if I had a group of 5,000 with similar demographics as the 50-person group, then to answer that question, yes.

Senator Leo W. Fraser, Jr., D. 4:
Thank you very much.

Senator Katherine W. Wheeler, D. 21:
Any further questions? Seeing none, thank you very much. Our last two speakers would be Suzanne Amidon first, then Yvonne Nanasi. After that the Committee is going to carry out its hearings in Rep's Hall for the next bill. So there will be a change of venue after these two people testify. I am going to ask Senator Hollingworth to deal with this and I am going to go work on my eye.

Suzanne Amidon – General Counsel - NH Hospital Association:
Good Morning, Madam Chairman, my name is Suzanne Amidon, General Counsel for the New Hampshire Hospital Association.
(See attached written testimony, Document #9).

Senator Beverly A. Hollingworth, D. 23:
Questions from the Committee? See none, thank you very much. Yvonne Nanasi.

Yvonne Nanasi– Director of Government Relations– BCBSNH:
Thank you very much Madame Chair, Members of the Committee I will be very brief, as I understand you have chiropractor next.
(See attached written testimony, Document #10).

Senator Beverly A. Hollingworth, D. 23:
Thank you very much. That ends those who have submitted a card wishing to speak. We do have a card from Judith Ryan in support of the bill but not wishing to speak. Thank you all for coming, I will close the hearing on **SB162.**

Hearing closed on SB162 at 10:30am.

Respectively submitted,
Linda Brosseau, secretary

Sen. Fraser

SB 162

This bill establishes standards for a voluntary health insurance purchasing alliance. The alliance would be run by a nonprofit corporation and would be available to small employers statewide. The operation of the alliance would be overseen by the Insurance Department.

Small employers need help providing health insurance coverage for their employees. On an individual basis, small employers simply do not have the resources to effectively shop around and negotiate and contract with health carriers. By consolidating purchasing responsibilities and resources, small employers will gain much-needed bargaining clout and purchasing savvy. They will also be able to give their employees something they do not now have but greatly desire–namely, choice of health plans. An added benefit is that certain administrative costs, such as costs associated with contracting, enrollment, and premium collection and payment, will be reduced through economies of scale.

Over the summer, I participated in the SB 494 study committee on purchasing alliances. We heard from experts on the subject and collected a great deal of information on the operation of purchasing alliances in other states. What I have concluded is that, if properly structured, a health insurance purchasing alliance can provide significant benefits to small employers and their employees with no significant downside.

Document #1

The health carriers have mostly opposed and lobbied against this idea, and there is something very interesting about that. What is interesting is that, for at least the last five years, the health carriers have been trying ~~desperately~~ to grow or consolidate. The reason they have given for wanting so very much to do this is the importance of market strength and economies of scale. And, indeed, there has been a great deal of market consolidation on the supply side of the health insurance market.

Unfortunately for the purchaser, there has been very little consolidation on the demand side. Today, with this bill, I put forward the old notion that what's good for the goose is good for the gander.

Document #2

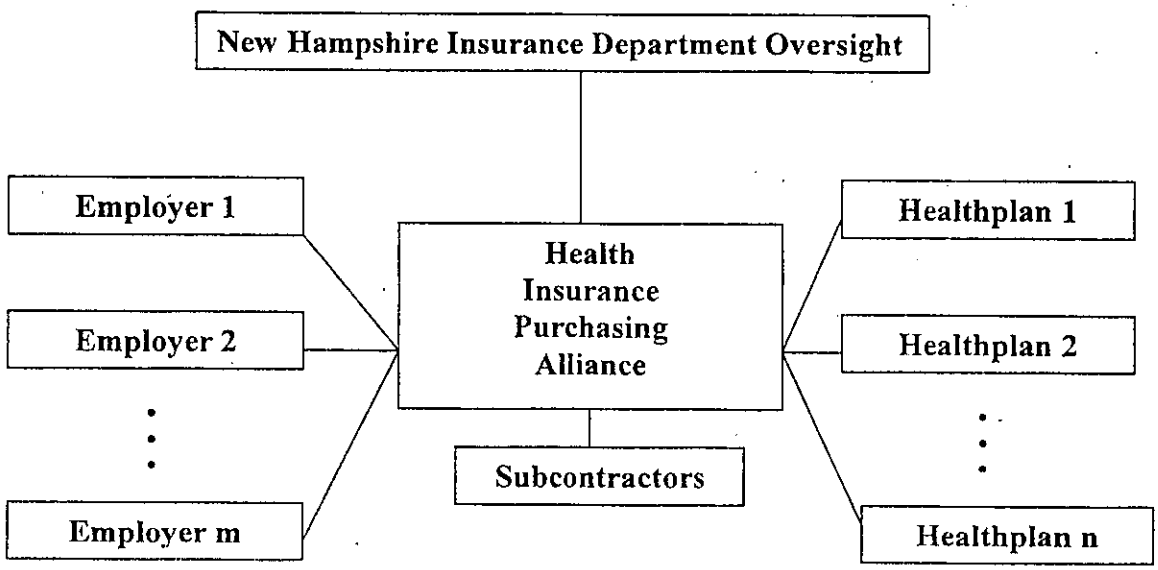
SB 162:

An act establishing the voluntary small employer purchasing alliance

What is a Health Insurance Purchasing Alliance (HIPA)?

A HIPA is a private organization through which businesses join forces to purchase health insurance for their workers. The primary goal of a HIPA is to obtain better value in purchasing health insurance by consolidating purchasing responsibilities and resources, thereby:

- increasing bargaining clout and purchasing expertise
- reducing the administrative cost of health plan contracting, enrollment, premium collection and payment for multiple employers, and
- giving consumers a meaningful choice of competing health plans.



What a HIPA does

- ✓ Negotiating and contracting
- ✓ Marketing
- ✓ Enrollment
- ✓ Premium collection and distribution
- ✓ Consumer information
- ✓ Data analysis and evaluation
- ✓ Plan performance measurement
- ✓ Quality improvement

What a HIPA doesn't do

- x Bear risk
- x Directly pay individual health care providers
- x Market for just one carrier
- x Provide health care services
- x Function as a health plan (HMO, PPO, etc)

A HIPA can help us achieve the following important health goals:

Reduce costs for health insurance by:

- aggregating purchasing power to negotiate with health plans
- reducing administration costs

Enhance employee choice of plans by:

- encouraging participation of multiple health plans
- allowing employees to choose among health plans available through the HIPA

Foster competition based on value by:

- ensuring consumers receive clear information about plans including plan quality
- requiring plans to offer standardized benefit packages for "apples to apples" comparisons
- reducing the opportunity for health plans to engage in risk selection and cost-shifting from other purchasers
- reducing the incentive for health plans to risk select by risk adjusting rates

Enhance quality by:

- providing consumers with information to compare plans for best value
- negotiating with plans to set specific quality improvement goals

Reduce the overall level of uninsurance by:

- making insurance more affordable
- discouraging risk selection

Why organize a HIPA for small employers?

Small employers have the most difficulty covering their employees. An alliance will facilitate the purchase of health insurance for small employers.

- Of the 54 million Americans between the ages of 18 and 65 who are employed in businesses with 100 or fewer workers, only 40% obtain health insurance from their employer compared with 83% of employees in firms employing 1,000 or more workers.

A HIPA will increase choice of plans available to its members

- Workers in small firms tend to have little choice of plans.
- In 1996, 80% of the small firms that offered coverage offered only one plan.
- Only 6% offered choice from 3 or more plans.

A HIPA can increase the efficiency of the health delivery system

- The cost of health insurance as measured by the difference between premiums and benefits paid (the "loading charge") is greater for small firms than for large firms. This is due to the fact that administrative costs involved in insuring a small employer can be high.

Document #29

SB 162: Questions and Answers

1. Q: Why is a small employer purchasing alliance needed?

   A1: Small employers have an especially hard time providing insurance coverage for their employees. They are much less likely than large employers to provide any coverage at all to their employees or to provide employee choice of plans. In addition, employee's out-of-pocket costs tend to be higher for small employers. This bill would provide a mechanism for small employers to band together, thereby giving them the same purchasing advantages (e.g., economies of scale, increased purchasing power) that large employers now enjoy.

   A2: Also, the health plans themselves are busily banding together for improved market position. This in itself increases the need for small employers to improve their own market position.

2. Q: Why do we need this kind of alliance? Why aren't the existing trade associations and trusts enough?

   A1: The existing group purchasing mechanisms are not available to most small employers.

   A2: The many of the existing group purchasing mechanisms are not large enough to get the kind of bargaining clout we are looking for and at the same time to offer choice of plans.

3. Q: How is it going to help us to create another government bureaucracy?

   A: This is not a government bureaucracy. This bill simply sets groundrules whereby a private nonprofit corporation will administer the purchasing alliance. The oversight function is performed by the Insurance Department.

4. Q: Isn't the small group market functioning well right now in the sense that there has been a lot of competition? If it ain't broke, why should we fix it?

A1: In the last few years, there has indeed been a fair amount of price competition in the small group market. This is because the name of the game has been market share. Health plans have opted for reduced margins and even significant losses in exchange for a chance at improved market share. But this is changing and plans are beginning to implement large price increases as they seek to recover from the rigors of vying for market share. At the same time, the market continues to consolidate on the supply side with only three plans having the lion's share of the market.

A2: Even with the increased price competition in this market in the past few years, things have still been far from adequate for the small employer. Many small employers cannot offer coverage or choice of plans to their employees. This puts them at a competitive disadvantage relative to employers in other states and in the world economy. The New Hampshire small employer could truly benefit from the economies of scale and increased bargaining clout that a purchasing alliance would offer.

5. Q: Isn't it true that small employers already have choice of plans and that an alliance would not improve this?

A: Certainly small employers have a choice in the current market. They can choose to contract with any of a number of health plans. But that is not the choice that we are talking about. We are talking about the ability of small employers to offer choice of coverage to their employees. Because of the administrative difficulty of contracting with health plans and because of health plan conditions about participation rates, most small employers who do offer coverage offer only one plan. So the only choice that is given to the employee is of the "Take it or leave it" variety. We will not have true competition in the small group market until we have consumer and not just purchaser choice of plans.

Document #3

Testimony for SB 162 – an act to establish the voluntary small employer health insurance purchasing alliance

Good morning Madame Chairwoman and members of the Committee, my name is David Larrivee and I am the Director of Market Relations for Tufts Health Plan. On behalf of Tufts Health Plan I thank you and your committee for the opportunity to testify on Senate Bill 162.

Tufts Health Plan is opposed to SB 162 because it is duplicative and unnecessary and potentially threatening to the healthy, competitive small group market presently existing in New Hampshire. Therefore, we do not see the need for yet another layer of bureaucracy.

In 1994, the New Hampshire Legislature passed small group market reform and since that time, a competitive environment has formed among the small group carriers. Small group carriers have seen a steady growth in the market, the number of small group policies has increased by 89%, the number of covered lives has increased by 31%, the average group size has declined, and the number of carriers writing in the small group market has grown.[1]

Given the growing small group market in New Hampshire, Tufts Health Plan opposes to SB 162 for a number of reasons.

First, the introduction of a Purchasing Alliance will not reduce costs. Fees assessed in connection with the operation of the Alliance will negate any cost savings to the small group employer and/or the consumer. For example, the proposed model calls for all member employers to pay the costs incurred or anticipated by the Alliance in connection with the operation of the Alliance.

Health plans would also incur costs should the Alliance develop uniform standards for data to be collected and provided to it and its members. New Hampshire HMOs already answer to a broad range of organizations that measure health care quality. These organizations include federal and state government agencies and independent not-for-profit review groups. One of these review groups, the National Committee for Quality Assurance (NCQA) serves as the national accrediting body for HMOs. The standards set by NCQA are purposely set high to encourage health plans to continuously enhance their quality of care.

In order to assure high quality patient care, Tufts Health Plan already maintains internal quality assurance and utilization management systems. These systems afford our members a level of accountability and protection. Tufts Health Plan's quality assurance programs also allow us to evaluate health outcomes and collect data in order to identify areas of strength and target resources to those areas that need improvement.

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[1] Senate Bill 711 final report, An Investigation Into the Effects of the New Hampshire Health Insurance Reform Law, RSA 420-G, pp. 47-48 (1977).

Health plans also collect and report HEDIS data (Health Employer Data and Information Set). HEDIS data is a core set of performance measures used to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance. HEDIS measures are constantly being refined and updated to meet the changing needs of employers and other purchasers.

SB 162 also calls for any marketing, advertisement, or education materials for health coverage sold through the Alliance to be approved by the Alliance prior to its use. At the moment, health plans have marketing materials that are approved both by their legal counsels as well as the Department of Insurance. Alliance approval of these marketing materials just adds another layer of administration, not to mention more costs for the health plans participating in the Alliance who would be required to pay funds into marketing pools.

If a Purchasing Alliance were to develop, two risk pools would be created in the current small group market. From here, there is potential for negative impacts on the existing and successful risk pool established by the small group law. For example, the small employers who did not belong to this Alliance could end up paying a higher cost for health care because of the risk selection imbalance. Furthermore, by requiring a standard product, there will be no incentive on the part of health plans to be creative in what they can or cannot offer to a small employer. From the employee's perspective, what is the incentive to chose one plan over the other? How does this foster a competitive environment in the marketplace? How will the Alliance explain the differences between the health plans?

Tufts Health Plan also believes that SB 162 would be harmful to those individuals who are already struggling to afford health insurance for themselves and their families. If the purpose of the proposed legislation is to lower costs, thereby increasing access for some portion of the presently uninsured segment of the population (the working poor), the proposed legislation is the wrong method. For example, other states which have enacted purchasing alliance legislation in the early 1990's faced enormous problems of adverse selection. The standardized products offered through the health insurance purchasing cooperatives were more expensive than the more innovative and streamlined products that could be offered outside of the cooperatives. Employers with health employee populations forced to the non-cooperative products, leaving those with disabilities and chronic illnesses to flood the cooperatives pool.

Furthermore, the current Alliance also allows any late enrollees to enroll in any health benefit plan that is available through the Alliance. This would mean an employee can choose not to enroll during standard open enrollment, find out they have a condition or illness that requires medical treatment later in the year and enroll to have the claims paid.

Finally, without knowing what level of enrollment is anticipated, it is difficult to predict the viability of the Alliance. Experience in other states demonstrates that states such as New Hampshire, with small populations, are inappropriate forums for the purchasing

alliance model. For example, Maine passed a purchasing alliance statute in 1996 and no voluntary pools have been created since the passage of these laws.

For these reasons, Tufts Health Plan opposes SB 162. I thank you and your Committee for this opportunity to address this very important issue this morning. I would be happy to answer any questions the Committee may have at this time.

Document #4

April 12, 1999

The Honorable Katherine Wheeler
Chair, Senate Committee on Insurance
Legislative Office Building
Room 102
Concord, NH 03301

RE: Senate Bill 162

Dear Senator Wheeler:

I am writing to express Harvard Pilgrim Health Care of New England's opposition to Senate Bill 162 – An Act Establishing the Voluntary Small Employer Health Purchasing Alliance.

Purchasing alliances, often referred to as Health Insurance Purchasing Cooperatives (HIPCs), have been tried in other states. Experience shows that, in all but the largest states, carriers offering coverage through the alliances lose money and cannot maintain themselves in the marketplace. In the smaller states, coverage offered through the HIPCs has typically been more expensive than other coverage available in the marketplace. Harvard Pilgrim believes that the result in New Hampshire would be the same, particularly given the number of requirements which would be applicable to carriers offering coverage through the HIPC.

In addition to opposing purchasing alliances in general, Harvard Pilgrim has serious concerns about many of the specific components of the proposed alliance. These concerns include:

- The eligibility requirements for coverage offered through the HIPC would be different than those applicable to the small group market, resulting in adverse selection against the HIPC products.
- The alliance could limit participation in the alliance to three (and possibly fewer) carriers, resulting in less choice for consumers.
- The lack of detail regarding the proposed risk adjustment mechanism.

The small group health insurance market in New Hampshire is functioning well. Many carriers are offering a variety of health plans to small businesses at competitive rates. In large part, this is the result of previous reforms enacted by the Legislature. Harvard Pilgrim does not believe that further legislative intervention in this market is warranted at this time.

For all of the above reasons, Harvard Pilgrim urges you to oppose Senate Bill 162. Thank you for your consideration.

Sincerely,

Thomas Gough
Direction, New Hampshire Operations and Development

STATE OF NEW HAMPSHIRE
DEPARTMENT of RESOURCES and ECONOMIC DEVELOPMENT
OFFICE of the COMMISSIONER
172 Pembroke Road P.O. Box 1856 Concord, New Hampshire 03302-1856

GEORGE M. BALD
Commissioner

603-271-2411
FAX: 603-271-2629
e-mail: g_bald@dred.state.nh.us

April 12, 1999

Members of the Insurance Committee

I am in support of SB 162 establishing a voluntary small employer health insurance purchasing alliance. Small businesses truly need this legislation. They typically have the most difficulty in obtaining health coverage for their employees. It would also make it more affordable for small businesses.

We deal with many small businesses on a daily basis, and the current number one problem is attracting and hiring qualified employees. Having the opportunity to provide health insurance will allow them to compete for experienced employees.

This is a reasonable proposal to assist small business owners to be more competitive and have the opportunity to grow and create new employment. I urge the committee to support the bill.

Sincerely,

George M. Bald
Commissioner

Document #5

Document #6

North Country
Health Consortium
25 Mt. Eustis Road, Littleton, NH 03561

Ammonoosuc Community Health Services, Inc.. Littleton, NH 03561

Androscoggin Valley Home Care Services, Inc. Berlin, NH 03570

Androscoggin Valley Hospital, Inc. Berlin, NH 03570

Androscoggin Valley Mental Health & Developmental Services Berlin, NH 03570

Coos County Family Health Services, Inc. Berlin, NH 03570

Littleton Regional Hospital, Inc. Littleton, NH 03561

North Country Home Health Agency, Inc. Littleton, NH 03561

Tri-County Community Action Program, Inc Berlin, NH 03570

Upper Connecticut Valley Hospital, Inc. Colebrook, NH 03576

Upper Connecticut Valley Mental Health & Developmental Services

Weeks Hospital Association, Inc. Lancaster, NH 03584

White Mountain Mental Health & Developmental Services Littleton, NH 03561

SENATE BILL 162: Health Insurance Purchasing Alliance
Summary of Testimony to Senate Insurance Committee

1. We have a potentially serious situation developing in the health insurance market for Northern New Hampshire.

2. Many employers have been faced with severe health insurance premium rate increases in recent months. This situation has created a scramble to find new, affordable sources of coverage within a market that already has very limited choice.

3. The proposed small business purchasing alliance offers an important vehicle for addressing this problem, particularly for Northern New Hampshire.

4. Northern New Hampshire communities are characterized by inter-related circumstances of lower median household income, greater self- and small-business employment, and higher rates of uninsurance or under-insurance relative to the rest of New Hampshire.

5. High rates of uninsurance and underinsurance are undoubtedly correlated with the higher rates of small business and self-employment. Among small employers (under 50 employees), 51 to 58 percent of businesses offer health insurance to their workers in contrast to large employers, of which 91 to 96 percent are estimated to offer insurance.

6. The difficulties faced by small employers in purchasing insurance are also factors that inhibit small purchasers' ability to use their purchasing dollars to improve quality or to participate meaningfully in the marketplace.

7. A group purchasing alliance could yield significant community benefit by:

   A) facilitating broader and more informed consumer choice;
   B) expanding access by making available more affordable health insurance options; and
   C) encouraging greater community involvement in health care issues by disseminating information on quality, cost, and outcomes to support value-based decision-making.

8. Such a plan could have widespread impact in Northern New Hampshire where small businesses are prevalent, plan choice is currently limited, and rates of uninsurance and underinsurance are high.

North Country
Health Consortium
25 Mt. Eustis Road, Littleton, NH 03561

Ammonoosuc Community
Health Services, Inc..
Littleton, NH 03561

Androscoggin Valley
Home Care Services, Inc.
Berlin, NH 03570

Androscoggin Valley Hospital,
Inc.
Berlin, NH 03570

Androscoggin Valley Mental
Health & Developmental Services
Berlin, NH 03570

Coos County Family
Health Services, Inc.
Berlin, NH 03570

Littleton Regional Hospital, Inc.
Littleton, NH 03561

North Country Home
Health Agency, Inc.
Littleton, NH 03561

Tri-County Community Action
Program, Inc
Berlin, NH 03570

Upper Connecticut Valley
Hospital, Inc.
Colebrook, NH 03576

Upper Connecticut Valley Mental
Health & Developmental
Services

Weeks Hospital Association, Inc.
Lancaster, NH 03584

White Mountain Mental Health
& Developmental Services
Littleton, NH 03561

TESTIMONY TO SENATE INSURANCE COMMITTEE

Good Morning. My name is Jonathan Stewart. I am the General Manager of the North Country Health Consortium - an organization formed by ten health and human service organizations serving Northern New Hampshire. The organizational members, which are listed on this handout, include four community hospital systems, two home care organizatio two community health centers, a mental health and developmental service agency, and a community action program. I am here today because I believe we have a potentially serious situation developing in the health insurance market for Northern New Hampshire. I am also here because I believe the proposed small business purchasing alliance offers an important vehicle for addressing this problem.

As you are aware, many employers have been faced with severe health insurance premium rate increases in recent months. Among our own consortium members, premium hikes are ranging from 30% to 49% for their employee health benefits. As health providers, we also encounter many examples of employers and employees facing similar difficulties fo maintaining adequate health coverage. This situation has created a scramble to find new, affordable sources of coverage within a market that already has very limited choice. The affect of the rate adjustment and limited choice in the health insurance market is a particula hardship for the many individuals and families employed in small businesses or who are self employed.

Northern New Hampshire Concerns

Northern New Hampshire communities are characterized by inter-related circumstances of lower median household income, greater self- and small-business employment, and higher rates of uninsurance or under-insurance relative to the rest of New Hampshire.

- Residents of Northern New Hampshire towns are nearly 4 times more likely than residents of other New Hampshire towns to live in a federally-designated underserved area due to limited access to care and poor economic conditions.

- Compared to the rest of New Hampshire, the northern region exhibits significantly higher incidence rates (i.e. >10% higher) for important preventable indicators such a mortality due to external causes (e.g. motor vehicle accidents, other accidents, suicide), maternal smoking, cancer of the lung, breast and colon, chronic obstructive pulmonary disease, and ambulatory care sensitive hospital admissions *(NewHampshire Primary Care Access Plan data; 1997).*

- The risk of being uninsured for an individual in Northern New Hampshire is 20% higher than for an individual in the rest of New Hampshire *(Behavioral Risk Factor Survey data; 1991-1995)*. People who are employed, particularly self-employed individuals or workers in low-wage industries, and their dependents may represent as much as 70% of the uninsured population.

- In 1997, 51% of employed individuals in Northern New Hampshire were employed in firms with fewer than 50 employees compared to 41% of employed individuals statewide. *(New Hampshire Employment Security data; 1997)*

The Small Business Challenge

The high rates of uninsurance and underinsurance are undoubtedly correlated with the higher rates of small business and self-employment.

- Across the nation, 62.5% of metropolitan county residents are insured through employment-related sources compared with 53.7% of non-metropolitan county residents *(Medical Expenditure Panel Survey; Agency for Health Care Policy & Research; 1997)*.

- The likelihood that health coverage is purchased by a group purchaser is directly related to the size of the group to be insured. In surveys of small employers (fewer than 50 workers), 51 to 58 percent of businesses offer health insurance to their workers in contrast to large employers, of which 91 to 96 percent were estimated to offer insurance *(Cantor, Joel C.; Stephen H. Long, and M. Susan Marquis, "Private Employment-Based Insurance in Ten States," Health Affairs 14(2):199-211; 1995)*.

- Among those employers that offer health insurance, most small purchasers choose to offer only one plan to minimize administrative costs and to maximize group size and purchasing power. The extent of employee choice often depends upon employer size; 32 percent of employers nationwide are estimated to offer only one health plan to their employees, but this varies from about 89 percent of very small firms (1 to 24 employees) to about 9 percent of very large firms (5,000 or more employees) *(President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry; 1997)*.

The difficulties faced by small employers in purchasing insurance are also factors that inhibit small purchasers' ability to use their purchasing dollars to improve quality or to participate meaningfully in the marketplace. Employers and employees in small firms often lack both the purchasing power and administrative capacity to obtain comparative information about health care quality or to apply available quality information in a meaningful way.

I might also say that this limited administrative capacity may be reflected in limited capacity to organize around legislation. One of the criticisms of the group purchasing alliance legislation I have been hearing is that there has not been widespread organization of small business to support it. I can tell you that every small business owner or representative of the small business community to whom I have talked about a group purchasing alliance has endorsed the concept. Perhaps the limited organized support of this legislation is indicative of the larger problem of limited time and capacity of small business owners to address health insurance issues; a situation that a group purchasing alliance would go a long way toward addressing.

The Health Purchasing Alliance Response

Considerable evidence now exists from a number of other States that health purchasing alliances can help to alleviate the problems of purchasing power and administrative capacity. The basic premise of a group purchasing cooperative is that by joining together, small groups can reduce their administrative costs, provide their employees with more choice, and have the ability to undertake value-based purchasing activities that are more readily available to larger group purchasers. At a minimum, such cooperatives can be the vehicle for effective consumer education on health care cost, quality and outcome issues thereby facilitating more informed participation in the healthcare marketplace. In many cases, such cooperatives have significant impact on the range of choice and affordability of insurance plans for health care consumers.

Such a plan could have widespread impact in Northern New Hampshire where small businesses are prevalent, plan choice is currently limited, and rates of uninsurance and underinsurance are high. It is our belief that the proposed purchasing alliance could yield significant community benefit by:

1) facilitating broader and more informed consumer choice;
2) expanding access by making available more affordable health insurance options; and
3) encouraging greater community involvement in health care issues by disseminating information on quality, cost, and outcomes to support value-based decision-making.

Considering the potential effect of the current insurance market environment on a historically fragile base of employer-sponsored insurance coverage, NCHC members believe that now is the time for action to avert a worsening health insurance situation in Northern New Hampshire.

Document #7

Lori Real, Director of Planning and Research
Department of Health and Human Services
Testimony on Senate Bill 162
Before the Senate Insurance Committee
April 12, 1999

Good morning, Madame Chairman and Members of the Committee. For the record, my name is Lori Real. I am director of the Office of Planning and Research, with the Department of Health and Human Services.

I am here today to express the Department's support for Senate Bill 162, which would allow small employers to come together to purchase health coverage from health plans.

We believe that the purchasing alliance can enhance employees' choice of health plans, give them better information on quality and performance, and help discipline market prices.

The Department recently conducted a broad public discussion about health care with a large number of citizens across New Hampshire. This work is described in the Department's October 1998 report titled *The New Hampshire Health Care System: Guidelines for Change.* This public input identified major concerns about the current health care system. Here are four leading concerns discussed in the report:

- concern about the affordability of health insurance
- concern about limited choice -- most employees can choose from only one plan
- concern about the lack of information to enable comparisons among health plans and make informed choice
- concern about the need to promote quality monitoring and improvement.

The experience of health insurance purchasing alliances in other states suggests that this can be a viable mechanism for addressing these concerns. The alliances can

- bring more employees under the health insurance system
- offer employees better value and lower premiums
- give employees more choice of health plans, and collect and disseminate comparative plan information
- collect information on the quality of health plans and negotiate based on quality.

Research on other states' models has shown that four characteristics are particularly important to the design of an effective purchasing alliance:

1) Insurance market rules inside the purchasing alliance must be consistent with insurance market rules that exist outside the alliance -- for example, to try to increase access or decrease premiums for high-cost or high-risk individuals could lead to adverse selection and turn the alliance into a repository for such individuals.

2) To maintain an effective bidding process, there needs to be a strong level of commitment to the goals of the purchasing alliance and the market rules that support it. Otherwise, people will be wary of entering into it.

3) Standardized benefit packages are needed to make comparison shopping possible and to eliminate the option of selecting good risks into a particular plan by benefit design.

4) The role of insurance agents must be maintained since small employers are accustomed to working with them and they continue to serve a useful role in marketing and enrollment functions.

The model presented in this bill incorporates these characteristics, and for that reason we support it.

We are prepared to work with the Committee as this bill moves forward.

I would be happy to answer any questions.

Document #8

New Hampshire Association of Health Underwriters - NHAHU
Independent Insurance Agents of New Hampshire - IIANH

Written Testimony for Senate Bill 162
April 12, 1999

Let me begin by stating that New Hampshire Association of Health Underwriters (NHAHU) and the Independent Insurance Agents of New Hampshire (IIANH) strongly support meaningful health care reform. We recognize the need for fundamental reforms in the health insurance market which would guarantee the availability and portability of coverage and consumer choice. And we compliment the Department of Insurance for recognizing the value of the health insurance broker and their (DOI) pursuit of meaningful market reform.

While pooled employer or group purchasing arrangements might be initially viewed as a way to increase access to health coverage in the small employer market, we have significant reservations and concerns regarding the utility and effect on the marketplace of such arrangements. In addition, New Hampshire health plans, which have recently received high honors from national publications *(U.S. News and World Report, October 5, 1998; and Newsweek, September 28, 1998),* are required to provide guaranteed acceptance of eligible employers

One of the alleged benefits of purchasing alliances is their ability to reduce administrative and marketing costs by performing many of the administrative functions currently performed by small employers or carriers. Contrary to reducing these costs and making coverage more affordable for small businesses, establishing alliances will require the creation of costly new administrative structures and/or bureaucracies to manage and operate the buying groups, which could offset any economies of scale.

In our opinion, these new bureaucracies would inadequately perform important services already being performed by commercial insurers and their agents; such as consumer education, marketing, and claims administrative functions. There is little reason to expect that the buying group's administrators can accomplish these tasks more efficiently than the commercial insurers and agents.

Furthermore, while a pooled employer arrangement may be able to obtain somewhat lower premiums due to its collective buying power, any economies of scale would be reduced by the fact of administering the health plans of many small employers is not the same as administering the health plan of a single large employer.

Additionally, the health underwriters and independent agents strongly believe that a HIPC should be required to meet the same statutory and regulatory requirements. The current legislation promotes an **"un-level playing field".**

1. The current legislation exempts the alliance from the current 37 1/2% participation requirement, and
2. The alliance will receive a significant government subsidy not available to commercial insurers or their agents.

Let's not forget that the health care alliance does absolutely nothing to address the most significant problems existing today in New Hampshire:

1. The individual health care marketplace,
2. The increasing costs and utilization of health care services, and
3. The significant lack of hospital competition

Our associations believe the health insurance market requires reforms to address the major concerns of our consumers. We have supported legislation in the current legislative session to provide the following:

1. HMO grievance procedures (HB647)	SUPPORT
2. Set up a health insurance consumer advocate, DOI (HB602)	SUPPORT
3. Establish a healthcare quality commission (HB624)	SUPPORT
4. Modifications to the definition of small group (HB473)	SUPPORT

In our opinion, the best argument in support of a health insurance purchasing cooperative is giving the choice to the ultimate purchaser -- the employee. However, should the State of New Hampshire spend thousand of dollars on the development of a HIPC when the 37 1/2% participation rules from August of 1998 can be repealed. As a result, employers can offer multiple health plans without the concern of cancellation from their health plan provider.

We pledge to continue to work with the Department of Insurance, employer groups, and others to protect and improve the health insurance market of New Hampshire. Thank you for your time and consideration.

Thomas M. Harte is a Benefits Consultant with Landmark Benefits Group, Salem, New Hampshire. He can be reached at (603) 898-8833.

THE DEBATE OVER A HEALTH INSURANCE PURCHASING COOPERATIVE

Issues	Supporters	Opponents
Health Care Cost	Aggregate purchasing power to negotiate with health plans and reduced administrative costs would reduce premiums.	New Hampshire is a community rated state. As such, has "aggregated" purchasing power with health care plans already exists. A HIPA could adversely affect the community rates by removing a portion of the population from the existing system.
Employee Choice	HIPA would encourage participation of multiple health plans, allowing employees to choose among several plans.	Employers enjoy the flexibility today to offer multiple plans to its employees. Repeal of the 37 1/2% requirement would improve employee choice.
Competition	HIPA would foster competition by mandating standardized benefits, reduce the opportunity for health plans to engage in risk selection, and reduce incentive for health plans to risk select by risk adjusting rates.	In 1995 legislation was implemented to eliminate risk selection and risk adjusted rates. In addition, standardized benefits may stifle competition by eliminating unique product differences.
Quality	HIPA would enhance quality by providing consumers with information to compare plans for best value and negotiate with plans to set specific quality improvement goals.	New Hampshire enjoys participation of the best rated managed care plans in the United States (U.S. News and World Report, October 5, 1998).
Uninsured Population	HIPA would reduce the uninsured population making insurance more affordable and discouraging risk selection.	HIPA could increase the uninsured population by making insurance more expensive with its impact on community rates.

AMERICA'S TOP HMOs

PLAN	PLAN TYPE	U.S. NEWS RATING	SCORE	PREVENTION (AVG=61%)	ACCESS TO CARE (ADULTS) (AVG=66%)	MEMBER SATISFACTION (AVG=62%)	PHYSICIANS' CREDENTIALS (AVG=80%)	ACCESS TO CARE (CHILDREN) (AVG=82%)	ACCREDITATION STATUS
MICHIGAN CONTINUED FROM PREVIOUS PAGE									
Paramount Health Care	HMO	★★★	80	68%	94%	69%	88%	95%	Full
Medical Value Plan	HMO	★★★	80	66%	95%	71%	89%	93%	Full
Health Alliance Plan of Michigan	HMO	★★★	78	68%	91%	59%	85%	89%	Full
M-CARE	POS	★★★	75	73%	85%	NR%	85%	90%	1-year
Blue Care Network–East Michigan	HMO	★★★	74	66%	89%	60%	84%	88%	Full/Merger
SelectCare HMO	HMO	★★★	74	66%	91%	53%	90%	87%	Full
Care Choices HMO/Mercy Health Plans	HMO	★★★	68	61%	95%	63%	89%	65%	1-year
Physicians Health Plan of Mid Michigan	HMO	★★★	62	61%	95%	74%	NR	91%	None
Physicians Health Plan of Mid Michigan Plus	POS	★★★	60	62%	83%	75%	NR	89%	None
Blue Care Network–Southeast Michigan	HMO	★★★	60	56%	86%	57%	91%	79%	Full/Merger
Blue Care Network–Mid Michigan	HMO	★★	58	57%	81%	65%	73%	75%	Full/Merger
NorthMed	HMO	★★	54	63%	74%	NR	59%	78%	None
Physicians Health Plan of West Michigan	HMO	★★	46	52%	94%	70%	NR	73%	None
Physicians Health Plan of Southwest Michigan	HMO	★★	44	50%	92%	69%	NR	88%	None
Physicians Health Plan of West Michigan Plus	POS	★	40	51%	68%	68%	NR	68%	None
Physicians Health Plan of South Michigan	HMO	★	37	46%	89%	70%	NR	75%	None
Physicians Health Plan of Southwest Michigan	POS	★	30	43%	79%	61%	NR	81%	None
Physicians Health Plan of South Michigan Plus	POS	★	21	41%	49%	70%	NR	65%	None
Priority Health–Michigan	POS	★	0	NR	94%	NR	78%	91%	Full
MINNESOTA									
Medica Commercial	POS	★★★	69	68%	93%	NR	91%	90%	Full
HealthPartners	HMO	★★	56	55%	94%	61%	88%	NR	Full
Central Minnesota Group Health Plan	HMO	★★	46	49%	72%	63%	80%	85%	Full
MISSOURI									
Kaiser Foundation–Kansas City	HMO	★★★	72	65%	91%	56%	84%	85%	Full
Principal Health Care of Kansas City	HMO	★★★	65	59%	94%	58%	87%	90%	1-year
Group Health Plan–St. Louis	HMO	★★★	65	64%	83%	60%	67%	54%	1-year
Exclusive Healthcare–Kansas City	POS	★★★	64	65%	NA	NR	91%	83%	None
Group Health Plan–St. Louis	POS	★★	54	57%	80%	58%	67%	53%	1-year
Principal Health Care of Kansas City	POS	★★	50	56%	77%	NR	87%	87%	1-year
Exclusive Healthcare–Kansas City	HMO	★★	46	52%	89%	NR	91%	83%	None
Blue Cross Blue Shield of Kansas City	HMO	★★	45	51%	54%	59%	75%	86%	Full
Health Partners of the Midwest	HMO	★	40	44%	82%	66%	76%	83%	None
United HealthCare of Kansas City Choice/Select	HMO	★	28	37%	84%	66%	77%	NR	None
United HealthCare of Kansas City Choice/Select	POS	–	–	37%	70%	65%	NR	NR	None
NEBRASKA									
Exclusive Healthcare–Omaha	HMO	★★★	73	64%	94%	60%	85%	89%	1-year
Exclusive Healthcare–Omaha	POS	★★★	70	63%	93%	57%	85%	91%	1-year
United HealthCare of the Midlands Select	HMO	★★★	62	57%	93%	66%	74%	90%	Full
HMO Nebraska	HMO	★★	52	50%	93%	59%	89%	87%	Provisional
United HealthCare of the Midlands Select Plus	POS	★★	48	54%	60%	70%	49%	82%	None
HMO Nebraska	POS	★	38	44%	89%	55%	89%	82%	Provisional
NEW HAMPSHIRE									
Tufts Health Plan	HMO	★★★★	99	80%	96%	71%	83%	96%	Full
Harvard Pilgrim Health Care	HMO	★★★★	99	81%	96%	65%	83%	96%	Full
Matthew Thornton Health Plan	HMO	★★★★	90	76%	95%	70%	71%	95%	1-year
Healthsource New Hampshire–CIGNA	HMO	★★★★	87	73%	96%	64%	83%	94%	Full
United HealthCare of New England	HMO	★★★	73	69%	94%	74%	NR	87%	Full
BC/BS Blue Choice–New Hampshire	POS	★★★	73	69%	81%	64%	72%	NR	None
United HealthCare of New England	POS	★★★	69	68%	78%	71%	NR	87%	Full
Aetna U.S. Healthcare–New Hampshire	HMO	★★	51	57%	88%	NR	87%	67%	None
Aetna U.S. Healthcare–New Hampshire	POS	★★	45	54%	78%	NR	87%	60%	None



prepaid income also gives Master the flexibility to pay for whatever he thinks works best for the long-term health of each patient. An HMO, says Master, "is only as good as its care for its sickest patient."

Master's home visit to Gentile is typical of what makes the CMA model work. In Gentile's small living room, Master explains why he thinks the quadriplegic should enter a rehabilitation hospital. Master wants Gentile, at 270 pounds, to shed a recent 30-pound weight gain that now taxes his diminished chest-wall muscles. Gentile's odds of developing pneumonia this winter are high. And pneumonia, explains Master, could easily lead to other health problems that would rob Gentile of both health and independence. Master knows Gentile wants to vacation in Las Vegas and tells him he can still go if he enters rehab soon. Says Master: "We want to back you off the edge of the cliff you're sitting on."

Spend to save. Gentile's weight-loss treatment would last two to four weeks and cost up to $8,500. There's no certainty that it would work. A typical insurer, Master says later, would reject such expensive and speculative therapy, although it would pay for any hospitalizations that resulted later from a pneumonia. But in Boston, a day in the hospital runs about $1,500, and Master would rather gamble on a costly action now. "You've got to spend money to save money," he explains.

A device gave a voice to James Lessard, relieving his 84-year-old mother, Genevive.

Master feared Gentile would be reluctant to interrupt his life to move to a rehab hospital. But it takes only a little prodding before Gentile agrees. His nurse practitioner—a CMA employee who visits regularly—already has laid much of the groundwork. She has had long talks with Gentile about rehab. Most important, it turns out, she has won support for it from his girlfriend, too.

Nurse practitioners are key to the CMA model. These highly trained nurses can make diagnoses and order treatments. Mary Glover, like the other nurse practitioners, spends most of her day on the road, treating 40 quadriplegics at their homes and even, at times, at their work-

The Honor Roll

These managed-care plans earned a top four-star rating in this year's U.S. News rankings of 271 plans. Scores (red) show performance on a scale of 0 to 100 in 28 measures of quality. The order reflects actual scores, which are rounded here. HMO means health maintenance organization; POS means point-of-service plan (note).

The rankings begin on Page 81.

Note: HMOs cover all or most charges for care received within a network of providers; members pay for care received outside the network. POS plans are similar but pay much of the cost of out-of-network care. Sources: National Committee for Quality Assurance (data); National Opinion Research Center (analysis).

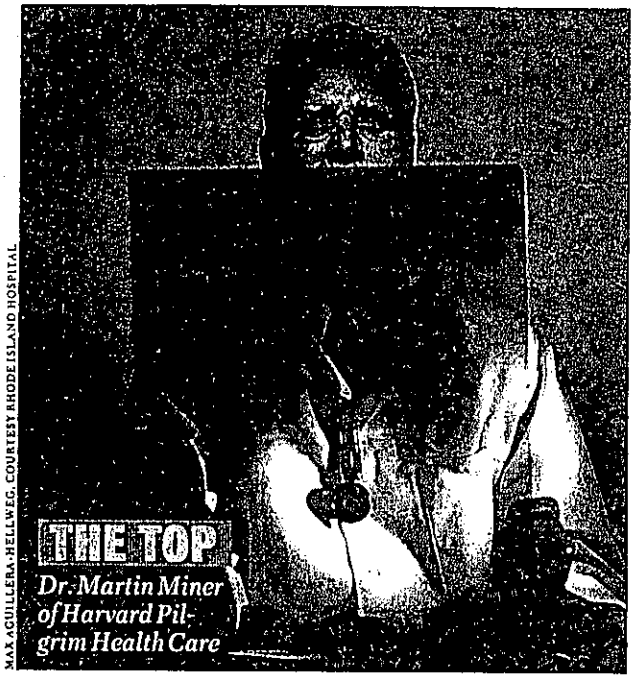
1. **Fallon Community Health Plan** HMO (MASS.) 100
2. **Finger Lakes–Blue Choice** HMO (N.Y.) 99
3. **Tufts Health Plan** HMO (MASS., MAINE, N.H., R.I.) 99
4. **Harvard Pilgrim Health Care** HMO (MASS., MAINE, N.H., R.I.) 99
5. **Welborn Health Plans** HMO (IND.) 97
6. **Healthsource Massachusetts–CIGNA** HMO (MASS.) 97
7. **BC/BS HMO Choice Maine** POS 96
8. **ConnectiCare** HMO (CONN.) 95
9. **Capital District Physicians' Health Plan** HMO (N.Y.) 94
10. **Blue Cross and Blue Shield of Massachusetts–HMO Blue** HMO 94
11. **Kaiser Foundation–Southern California** HMO 94
12. **Preferred Care** HMO (N.Y.) 93
13. **Group Health Cooperative of South Central Wisconsin** HMO 93
14. **Health New England** HMO (CONN., MASS.) 92
15. **Healthsource Maine–CIGNA** HMO 91
16. **Matthew Thornton Health Plan** HMO (MASS., MAINE, N.H., VT.) 90
17. **BC/BS HMO Maine** HMO 90
18. **HealthAmerica of Pennsylvania–Pittsburgh** HMO 90
19. **Blue Care Health Plan** HMO (CONN.) 89
20. **Kaiser Foundation–Northeast** HMO (CONN., MASS., N.Y., VT.) 89
21. **Finger Lakes–Blue Choice** POS (N.Y.) 88
22. **Health Care Plan–New York** HMO 87
23. **HMO–CNY** HMO (N.Y.) 87
24. **Blue Care Health Plan** POS (CONN.) 87
25. **Healthsource New Hampshire–CIGNA** HMO (MASS., N.H.) 87
26. **Network Health Plan of Wisconsin** HMO 86
27. **Keystone Health Plan Central** HMO (PA.) 86
28. **Health Alliance Medical Plans** HMO (ILL.) 85
29. **Independent Health–Western New York** POS 84
30. **Keystone Health Plan West Blue** HMO (PA.) 84
31. **Group Health Cooperative of Eau Claire** HMO (WIS.) 84
32. **Physicians Plus Insurance** HMO (WIS.) 83
33. **HealthPlus of Michigan** HMO 83
34. **M-CARE** HMO (MICH.) 83
35. **Independent Health–Western New York** HMO 83
36. **HealthPartners Health Plans–Phoenix** HMO (ARIZ.) 82
37. **Valley Health Plan** HMO (WIS.) 82
38. **Priority Health–Michigan** HMO 82
39. **Kaiser Foundation–Ohio** HMO 82
40. **Kaiser Foundation–Northern California** HMO 82

Ranking the Health Plans

NEWSWEEK'S annual survey gauges how well HMOs are serving their members

FOR NEWSWEEK'S THIRD annual ranking of managed-care plans, we surveyed more than 200 plans about practices that are known to improve families' health. Our rankings cover both classic health-maintenance organizations (whose members receive all their care from physicians within a network) and point-of-service plans (which cover some out-of-network services). We gauged performance in three areas—keeping members healthy, treating acute illness and managing chronic conditions—both for adults and for children. Working with the Foundation for Accountability, an Oregon-based nonprofit group, we monitored several measures of care within each of those categories.

We graded the plans on a curve. The one that performed best in a given category received a perfect 100 percent and the worst received a zero. So the letter grades in the columns below represent each plan's standing in relation to the others that provided information. The discrepancies were sometimes large. For example, the proportion of pregnant women who get prenatal care during their first trimester was as high as 99 percent in some plans, while in others it was only 38 percent.



MAA AGUILLERA-HELLWEG, COURTESY RHODE ISLAND HOSPITAL

THE TOP
Dr. Martin Miner of Harvard Pilgrim Health Care

The letter grades in the first column (Plan Ranking) represent each plan's overall performance. To calculate this general measure of excellence, we weighted kids' care at 30 percent and adult care at 70 percent, reflecting the plans' overall membership. In addition to quality grades, we've presented two other key measures for consumers: satisfaction and accreditation. To arrive at a satisfaction score, we subtracted the number of members who said they were highly dissatisfied from the number who said they were highly satisfied. Though this score was not factored into a plan's overall grade, it enables you to see how well different plans are doing at keeping their members happy. The accreditation column tells you whether a plan has passed muster with the National Committee for Quality Assurance in Washington.

As you scan the columns below, remember that a plan's overall grade is less important than its scores within each category. The needs of a 50-year-old with high blood pressure are very different from those of a 30-year-old with young children at home—and a plan that's perfect for one of those people may not work well for the other. When you're shopping for good health care, the difference is in the details.

	Overall			Adult care			Kids' care		
Rank/plan/state	PLAN RANKING	SATIS-FACTION	ACCRED-ITATION	STAYING HEALTHY	GETTING WELL	LIVING W/ILLNESS	STAYING HEALTHY	GETTING WELL	LIVING W/ILLNESS
1 Harvard Pilgrim Health Care, Mass.	A	B	yes	B	A	A	A	A	A
2 Tufts Health Plan, Mass.	A	A	yes	B	A	A	A	A	A
3 HMO Blue, Mass.	A	B	yes	A	A	A	A	B	B
4 Blue Choice, Rochester, N.Y.	A	B	yes	A	A	A	A	B	B
5 Group Health Cooperative of Puget Sound, Wash.	A	B	yes	A	B	A	B	B	B
6 United Healthcare of New England, R.I., HMO*	A	B	yes	B	A	A	A	A	B
7 Kaiser Foundation Health Plan of Hawaii	A	B	yes	B	B	A	B	B	B
8 Healthsource Massachusetts	A	B	yes	A	A	A	A	C	B
9 Anthem Blue Cross and Blue Shield of Connecticut	A	B	yes	B	B	A	A	B	B
10 United Health of Wisconsin Inc., POS†	A	B	yes	A	B	A	B	B	B
11 Kaiser Foundation Health Plan of Ohio	A	B	yes	B	B	A	B	B	A
12 Kaiser Foundation Health Plan–Northern California	A	B	yes	B	B	A	B	B	A
13 Kaiser Foundation Health Plan of Colorado	A	B	yes	A	A	B	B	B	B
14 Matthew Thornton Health Plan, N.H.	A	A	yes	A	A	B	A	A	B
15 Kaiser Foundation Health Plan–Southern California	A	B	yes	B	B	B	A	B	A
16 Fallon Community Health Plan, Mass.	A	A	yes	B	A	A	A	B	B
17 Health Alliance Plan, Detroit, Mich.	A	B	yes	B	B	A	B	B	B

*HEALTH MAINTENANCE ORGANIZATIONS. †POINT-OF-SERVICE PLANS. THE FOUNDATION FOR ACCOUNTABILITY, A NONPROFIT DESIGNER OF HEALTH-CARE QUALITY MEASURES AND INFORMATION TOOLS, ADVISED NEWSWEEK ON SURVEY DESIGN AND ANALYSIS. OVERALL SCORES ARE WEIGHTED 30 PERCENT KIDS, 70 PERCENT ADULTS, TO REFLECT MEMBER POPULATION.

DOCUMENT # 9

New Hampshire Hospital Association

Testimony in Support of HB 162,
Establishing Voluntary Small Employer Health Insurance Purchasing Alliance
April 12, 1999
Senate Insurance Committee

Good Morning, Madam Chairman. My name is Suzanne Amidon, General Counsel for the New Hampshire Hospital Association, which represents acute care and specialty care hospitals in New Hampshire. I am here to speak in support of HB 162.

The mission of the New Hampshire Hospital Association is "improve health" and one of our objectives is to increase access to health care by developing and supporting innovations to increase access. Our members have developed clinics which offer care on a free basis or on a sliding scale based on income, developed insurance programs for increased community based access, and even partnered with insurers to help offer small employers affordable health coverage.

The purpose of this legislation, to increase affordability of health care coverage by allowing small employer to work together to improve their bargaining power, furthers the objective of making insurance more accessible to working families in this state. We believe this is a complement to the Small Group Reform legislation initiated in this body and enacted into law 1995. It helps small employers to join in a purchasing alliance, on a voluntary basis, to increase their leverage in providing, designing and paying for health insurance for their employees and their families.

We know the Insurance Department may offer amendments to this proposal, however, we hope this Committee will vote "ought to pass" on some version of a small group purchasing alliance.

Thank you for your attention. I'll be happy to answer any questions you may have.

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Document #10

BlueCross BlueShield of New Hampshire

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Senate Insurance Committee
April 12, 1999

RE: SB 162 - Employer Health Care Purchasing Alliance
Submitted by: Yvonne Nanasi, BCBSNH Director of Government Relations

Blue Cross and Blue Shield of New Hampshire (BCBSNH) continues to support reforms in the individual and small group market that provide access and availability of health care insurance to the citizens of New Hampshire. BCBSNH agrees with the Governor and the sponsors of SB 162 that we must continue to explore health care system alternatives and actively seek out innovations. The next major health care market reform step that New Hampshire takes must be as widely discussed and as carefully scrutinized as were the 1994 reforms. Forming a statewide health care purchasing cooperative or alliance for small businesses is a major step. It is a step that can have far reaching impacts in the state's insurance market and health care services system.

Rather than base New Hampshire's next major health reform initiative on a theoretical model, the reform needs to be built upon gathering information from other similar state's and testing the New Hampshire small business market's demand for this new innovation. This is particularly important as recent studies have shown that New Hampshire's small group market is viable and, since the 1994 reforms, small employer insurance has expanded to include more family coverage.

As the state's largest insurer and in the best interest of our members - many of whom are small employers, BCBSNH would rather learn from other state's experiences rather than repeat their problems. We have spoken with several of our Blue Cross and Blue Shield plan colleagues in other states who have experience with the type of alliance being proposed in the bill. These conversations and the literature provided encouraged us to recommend that legislators consider the following while crafting this type of major step in New Hampshire's health care reform.

Our research, thus far, indicates that about 14 states have passed legislation to create or encourage the development of some form of employer health care purchasing cooperative or alliance. The success or failure of the concept varies from state to state for a variety of reasons. The major initial considerations we would ask legislators to consider before enacting SB 162 include:

* Start-up and operating costs for an employer's purchasing alliance are significant and crucial to its success. The majority of states that have fashioned lasting alliances found that the start-up funding for product design, marketing and administration was not only essential, but, more than anticipated and needed for a longer period of time than expected. For example, in 1993, North Carolina allocated $3.5 million to support alliance formation. In Florida, the legislature provided $275,000 per alliance (regional alliances) for the first year and $138,000 for the second year in addition to considerable administrative assistance from a state agency.

* Unsuccessful alliance efforts are available to learn from. Last year in Kentucky, legislation was proposed to "shut down" its purchasing alliance (supported by the Kentucky Insurance Department). When participating in the Kentucky Alliance, employers have to accept the standardized benefits that negotiated by the Alliance. In Kentucky the promised 1.5% administrative fee for alliance members was realized at about 4%. In addition to the small employers souring over the administrative fee increase, the university system and the state employees were not agreeable to the standardized plans as they could negotiate better deals with insurers. Furthermore, it seems that the third party administrator was not able to handle

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the alliance appropriately.
North Carolina and Ohio alliances have encountered difficulties in rural areas where the employers are interested but the insurers are not.

* Market segmentation and adverse selection are concerns. In smaller states that guarantee issue and community rate, like New Hampshire, there are the concerns among policy makers that voluntary quasi-governmental alliances will become magnets for high risk groups and fall into a death spiral of increasing costs and rates. Most alliance administrators strive to make their benefit plan offerings attractive enough to appeal to all small groups but much depends upon state's mandated benefit levels.
A small employer health care purchasing cooperative or alliance may segment the small group market to the disadvantage of those who are not participating, especially if the start-up or administrative costs are subsidized. Those employers who elect or are able to participate in the alliance may have healthier groups and be a better risk for insurers (See attached research funded by The Commonwealth Fund on the need for market adjustment mechanisms for alliances).

These and other considerations such as the composition of the alliance board of directors, ensuring a competent administrator, the reporting process, insurer participation requirements need to be discussed in order to craft an alliance mechanism for small employers that preserves the viability of the small group market, avoids the mistakes made by other states and moves our successful state reforms a step further.

Rather than create and fund a new bureaucracy, some states elected to enact very simple enabling legislation that allows for the formation of private nonprofit health purchasing alliances. This approach has been very successful in some states as the risk of operating the alliance remains among its' members - the employers. It would allow the state to test the potential interest and the ability of an alliance to function under current health care statutory requirements. Currently, NH law does not allow a different types of employer groups to form for the sole purpose of obtaining health insurance coverage. Changing this provision in our law may merit consideration.

In summary, BCBSNH supports the purpose and intent articulated in SB 162. Small Group Purchasing Cooperatives or Alliances have worked to the benefit of small employers in California and in some regions of other smaller states. Every opportunity that encourages small businesses to provide health insurance options to their employees should be sought out and carefully reviewed. BCBSNH is willing to tap into our nation-wide health care insurance resources in order to work with legislators on developing the next step in health insurance market reform that will work for New Hampshire's small businesses.

Directory of Consumer-Choice Health Purchasing Groups

compiled by the Institute for Health Policy Solutions

CALIFORNIA **Pacific Health Advantage (PacAdvantage)** *Date coverage available:* July 1993 *Size of employers:* 2-50 employee firms. Employers of any size if coverage is obtained through a qualifying trade association More Information	CONTACT INFORMATION *221 Main St.* *Suite 1500* *San Francisco, CA 94105* *949-766-1905*
COLORADO **The Colorado Health Care Purchasing Alliance** *Date coverage available:* November 15, 1995 *Size of employers:* Any size. More Information	CONTACT INFORMATION *501 South Cherry, Suite 900* *Denver, CO 80226* *303-333-6767* *303-322-3830/fax* *800-996-CHIP* *Info@alliance-colorado.org*
CONNECTICUT **CBIA Health Connections** *Date coverage available:* January 1, 1995 *Size of employers:* 3-50 More Information	CONTACT INFORMATION *350 Church St.* *Hartford, CT 06103-2022* *860-244-1900* *860-278-8562/Fax* *www.cbia.com*
FLORIDA **Florida Community Health Purchasing Alliance** *Date coverage available:* June 1, 1994 *Size of employers:* 1 to 50 employee firms More Information	CONTACT INFORMATION *PO Box 31214* *Tampa, FL 33631-3214* *813-286-2357 or 1-800-599-4816/fax* *1-800-4MYCHPA* *www.chpa.com*
ILLINOIS **IMA - Health Options** *Date coverage available:* October 1998 *Size of employers:* 2 to 50 employee firms More Information	CONTACT INFORMATION *Insurance Department* *IMA* *303 W. Madison, Suite 600* *Chicago, IL 60606* *800-482-0462*
MONTANA **Community Health Options** *Date coverage available:* January 1, 1998 *Size of employers:* 2 or more employees More Information	CONTACT INFORMATION *PO Box 4121* *Missoula, MT 59806* *406-721-6275* *No webpage, but questions can be emailed to Bill McDonald at:* *Wjmcdon@montana.com*
NEW YORK **Long Island Health Alliance** *Date coverage available:* February 1995 *Size of employers:* 3-50 employees More Information	CONTACT INFORMATION *Ellen Bass* *Director of Operations* *80 Hauppauge Rd.* *Commack, NY 11725-4495* *516-493-3008* *516-499-0167 FAX* *www.liassoc.com*
NEW YORK **New York Business Group on Health** *Date coverage available:* Mid- 1999 *Size of employers:* 2-50 employees More Information	CONTACT INFORMATION *New York Business Group on Health* *386 Park Ave. South* *Suite 508* *New York, NY 10016* *212-252-7440 x13*

NORTH CAROLINA **Caroliance** *Date coverage available:* November 15, 1995 *Size of employers:* Self-employed individuals and businesses with fewer than 50 employees More Information	CONTACT INFORMATION *State Health Plan Purchasing Alliance Board* *501 North Blount Street* *Raleigh, NC 27604* *800-873-6464* *www.caroliance.com* *ncshppa@mindspring.com*
OHIO **Council of Smaller Enterprises (COSE)** *Date coverage available:* 1974 *Size of employers:* 1 to 250 employees More Information	CONTACT INFORMATION *COSE* *200 Tower City Center* *50 Public Square* *Cleveland, OH 44113-2291* *216-621-3300* *888-304-GROW* *www.clevelandgrowth.com*
OREGON **Associated Oregon Industries** *Date coverage available:* August 1, 1997 *Size of employers:* 2-50 employees More Information	CONTACT INFORMATION *PO Box 12519* *Salem, OR 97309-0519* *503-588-0050* *503-588-0052/fax* *800-452-7862* *www.aoi.org* *Questions can be emailed to: kearls@aoi.org*
TEXAS **Texas Insurance Purchasing Alliance** *Date coverage available:* February 1, 1995 *Size of employers:* 2-50 employees More Information	CONTACT INFORMATION *1005 Congress Avenue* *Suite 550* *Austin, Texas 78765* *512-472-3956* *512-474-0167/fax* *800-839-8472*
UTAH **Care of Utah** This for profit consumer choice organization was formerly affiliated with the Utah employer coalition, Utah Health Cost Management Foundation.	CONTACT INFORMATION *801-355-2273*
WASHINGTON **HealthChoice** *Date coverage available:* July 1, 1996 *Size of employers:* 3 or more employees More Information	CONTACT INFORMATION *PO Box 658* *Olympia, WA 98507-0658* *206-943-1600* *206-943-5811/fax* *800-521-9325*

CHPGs on this chart have a Board of Directors with conflict of interest provisions and members who represent small employer consumers, offer a choice of multiple competing health plans, and have standardized benefits. All CHPGs meeting these requirements may not be included. Please contact the IHPS if you know of a small employer purchasing program that should be included.



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Countrywide

Group health purchasing pools listed by state

This list, compiled by the Institute for Health Policy Solutions, is not comprehensive. It focuses on groups that offer recipients a choice of health plans. If you don't see your state or region here, check with your local Chamber of Commerce or your state's insurance department to see if there is a group health insurance purchasing alliance.

State	Plan	Size of Firm	Region	Phone Number
California	Health Insurance Plan of California	2-50 employees	Statewide	(800) HIPC-YES
Colorado	Colorado Health Care Purchasing Alliance	Any size	Statewide	(800) 996-CHIP or (303) 333-6767
Connecticut	CBIA Health Connections	3-50 employees	Statewide	(860) 244-1900
Florida	Florida Community Health Purchasing Alliance	1-50 employees	Statewide (8 regional groups)	(800)-4MYCHPA or (813) 286-2357
Illinois	IMA - Health Options	2-50 employees	Chicago area	(800) 482-0462
Montana	Community Health Options	2 or more employees	None listed	(406) 721-6275
New York	Long Island Health Alliance	3-50 employees	Long Island plus Brooklyn, Queens, Nassau, and Suffolk Counties	(516) 493-3008
New York	New York Business Group on Health (not available until mid-1999)	2-50 employees	Five boroughs of New York City	(212) 788-8119
North Carolina	Caroliance	Fewer than 50 employees	Statewide	(800) 873-6464
Ohio	Council of Smaller Enterprises (COSE)	1-250 employees	Northeast Ohio	(888) 304-GROW or (216) 621-3300
Oregon	Associated Oregon Industries	2-50 employees	Statewide	(800) 452-7862 or (503) 588-0050
Texas	Texas Insurance Purchasing Alliance	2-50 employees	Statewide	(800) 839-8472 or (512) 472-3956
Utah	Care of Utah	None listed	None listed	(801) 355-2273
Washington	HealthChoice	3 or more employees	Statewide	(800) 521-9325 or (206) 943-1600

Source: Institute for Health Policy Solutions

Back to: Strength in numbers: Group health for your small business

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EMPLOYER PURCHASING COALITIONS AND MEDICAID: EXPERIENCES WITH RISK ADJUSTMENT

Melinda J. Beeuwkes Buntin and Joseph P. Newhouse, Harvard University
May 1998
Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to the Fund or its directors, officers, or staff.

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EXECUTIVE SUMMARY

Few problems in American health policy are more important—or more difficult to solve—than the problem of risk selection. Wherever buyers of health insurance are able to choose between two or more insurance options, some insurers may by chance enroll a group of members who are sicker or healthier than average. In addition, health plans have a clear financial incentive to induce healthier enrollees to select them and discourage sicker ones. Thus, the societal benefits of competition among health plans will never be fully achieved until incentives to select healthy enrollees are replaced by incentives to provide high-quality, cost-effective care.

Private employers, insurance purchasing coalitions, and Medicaid and Medicare managed care programs that offer a choice of health plans are all faced with the risk selection problem. In response, many analysts have called for the use of "risk adjusters" that would bring payments to health plans into line with the expected cost of caring for enrollees. This paper reviews a range of risk adjustment strategies currently in use in programs other than Medicare, including state Medicaid agencies, state employee health plans, state insurance pools and purchasing cooperatives, and business coalitions.

The experiences of these organizations offer several lessons. Their efforts confirm that implementing risk adjustment is very difficult, and that few entities are ahead of the Medicare program in using diagnosis-based risk adjustment. They prove that diagnostic risk adjustment systems can be implemented successfully, and that health plans seem willing and able to provide the data needed for diagnostic risk adjustment. They also show that less sophisticated systems, such as high-cost condition pools, are easier to implement than comprehensive risk adjustment systems but potentially less valuable. Another method, the "ceding" of high-cost cases back to fee-for-service coverage, has not been tried but should prove relatively easy to implement. Finally, it seems clear that the movement of sicker and disabled populations into Medicaid managed care programs increases the need for risk adjustment and that implementing risk adjustment methods for disabled Medicaid managed care enrollees is particularly urgent.

INTRODUCTION

Few problems in American health policy are more important—or more difficult to solve—than the problem of risk selection. Wherever buyers of health insurance are able to choose between two or more insurance options, some insurers may by chance enroll a group of members who are sicker or healthier than average. In addition, health plans have a clear financial incentive to induce healthier enrollees to select them and discourage sicker ones. Thus, the societal benefits of competition among health plans will never be fully achieved until incentives to select healthy enrollees are replaced by incentives to provide high-quality, cost-effective care.

Private employers, insurance purchasing coalitions, and Medicaid and Medicare managed care programs that offer a choice of health plans are all faced with the risk selection problem. In response, many analysts have called for the use of "risk adjusters" that would bring payments to health plans into line with the expected cost of caring for enrollees. This paper reviews the strategies to reduce risk selection being used in health insurance programs other than Medicare, following up on a previous paper (also produced with support from The Commonwealth Fund) that reviewed risk selection in the Medicare program and made a number of recommendations that were adopted in the Balanced Budget Act of 1997.

This review is not a comprehensive account of all the risk adjustment schemes currently in use. Even so, this sample shows decisively that, despite the theoretical benefits of risk adjustment, very few state Medicaid agencies or private employers have attempted to adjust payments to health plans to take account of risk. Rather, the conditions that foster risk selection seem to be increasing. In 1995, 62 percent of all workers offered insurance by their employers were given a choice among two or more health plans; the comparable percentage in 1991 was 46 percent. In firms with more that 200 employees, 84 percent of workers had such a choice in 1995, a growth of nine percentage points since 1993. This growth reveals a large and growing potential for risk selection among health plans.

THE PROBLEM OF RISK SELECTION

Purchasers of health insurance, both public and private, have found that attempts to contain costs by enrolling beneficiaries in managed care plans can be stymied by risk selection. Risk selection is especially likely to occur when beneficiaries are given a choice of remaining in a fee-for-service health insurance plan or enrolling in a managed care plan, since those who choose managed care tend to be healthier than average. If the managed care plan premium reflects the average rate for the entire group (or worse, if it reflects the average rate for those remaining in the indemnity plan), costs will rise. HMOs may attract so healthy a group of enrollees that even relatively low managed care premiums produce higher overall costs to the payor.

Medicaid managed care plans that feature voluntary enrollment are especially vulnerable to this problem. To apply for a federal waiver to

enroll Medicaid beneficiaries in managed care, a state must demonstrate that its capitation rate is below the average fee-for-service cost. As a result, state Medicaid agencies have historically set payments to health plans at 95 percent of the average cost of caring for a fee-for-service enrollee. Over time, favorable selection pushes up the average costs for beneficiaries remaining in the fee-for-service arrangement, thus raising HMO payments. In Medicare, where this cycle has also occurred, the Balanced Budget Act of 1997 broke the link between changes in the average cost of fee-for-service enrollees and changes in the capitated amount paid to health plans.

Like Medicare payments, Medicaid capitation payments are usually adjusted according to an enrollee's age, gender, and eligibility category, and place of residence is often weighed, as well. However, it appears that no comprehensive assessment of the predictive power of these adjusters within the Medicaid context has been conducted. Studies in the Medicare and private employer-sponsored contexts have not found these variables to be strongly predictive, and there is no reason to believe that the situation would differ markedly in Medicaid. Indeed, an investigation of the predictive power of these factors in the disabled Medicaid population found that age and sex predicted only 0.2 to 0.8 percent of the variation in disabled beneficiaries' annual costs, a percentage roughly similar to that predicted in Medicare by the adjusted average per capita cost (AAPCC).

As has also happened under Medicare, states may increase their overall Medicaid costs when they implement managed care programs. A RAND study of a Medicaid managed care demonstration found that a voluntary Medicaid HMO that appeared to reduce utilization had actually produced higher expenditures, after controlling for selection. Freund and colleagues, in an evaluation of six early Medicaid managed care demonstrations, found that "the rates established in several of the demonstration sites in the years examined were not accurate enough to yield the expected 5-to-10 percent savings." In fact, they found that costs in two sites were higher than they would have been in the absence of the demonstration.

Selection can potentially increase overall costs for private employers, as well. The Federal Employees Health Benefit Program, for example, has experienced problems with risk selection in its "high-option" indemnity insurance plan. Because government payments are tied partly to this plan but not to all plans, overall government costs may well have increased.

Most observers recognize that adjusting health plan premiums for risk can affect the terms of competition between health plans: plans may compete to deliver care efficiently to a given risk or they may compete by selecting individuals with lower-than-average service needs. Without competition over the efficient delivery of care, however, real savings for purchasers, including Medicaid and Medicare, are difficult to achieve. Because risk adjustment techniques attempt to bring health plan payments into line with the expected costs of caring for the individuals enrolled, competition to select good risks becomes less profitable.

The most intensive and promising research on risk adjusters has concentrated on diagnoses and prior use of health care services. The Health Care Financing Administration is funding two competing diagnosis-based risk

adjustment models for the Medicare population: the Ambulatory Care Group (ACG) system being developed by Jonathan Weiner and colleagues at Johns Hopkins University, and the Diagnostic Cost Group (DCG) system being developed by Arlene Ash and colleagues at Boston University. Another leading risk adjustment system for disabled Medicaid beneficiaries, the disability payment system, or DPS, is being developed by Richard Kronick and colleagues at the University of California, San Diego. As summarized in our earlier study, these methods still leave substantial room for risk selection, but they improve sufficiently on traditional methods to be worthy of implementation on a large scale.

RISK ADJUSTMENT BY STATES AND EMPLOYERS

Medicaid programs, states, and business coalitions have developed a variety of risk adjustment strategies, despite the absence of intensive, well-funded research on risk adjusters for their own populations. Their strategies include adapting the risk adjusters developed for the Medicare population, using the DPS, developing simpler risk adjustment methods focused on high-cost conditions, and negotiating premiums with health plans based on estimates of population risk.

State Medicaid Agencies

State Medicaid agencies appear to be in a particularly good position to implement risk adjustment. As they enroll new populations in managed care plans, for example, these agencies have access to comprehensive fee-for-service claims data that could be used for diagnostic adjustment. They also set standards for participation by health plans—a power that could be used to require participating plans to submit diagnostic data. According to Kronick and Dreyfus, however, Medicaid programs have done "more planning than implementation of health-based payment." Indiana, Wisconsin, and Ohio have used prior expenditures to adjust payments for a small number of patients in voluntary enrollment programs, and Minnesota and Oregon are now holding public hearings on risk adjustment.

Two states—Maryland and Colorado—have implemented more ambitious programs of risk adjustment. Maryland's Medicaid managed care program is using diagnostic adjustment. Colorado's system for the disabled Medicaid population is under consideration in other states. A more detailed look at developments in these two most advanced states may provide useful lessons.

Maryland. As part of Maryland's new Section 1115 Medicaid Managed Care program, participating HMOs are paid diagnosis-based capitation rates for many of their enrollees, using a risk adjustment methodology based on the ACG system. The program began enrolling beneficiaries in July 1997.

Under the ACG risk adjustment system, beneficiaries are assigned to groups based on diagnoses in their claims history. The cost of caring for beneficiaries in each group is then assessed and used as a basis for payment or cost estimation. In Maryland, groups with similar costs have been further combined into "resource adjusted categories." The costs associated with each group and category were calculated based on adjusted fiscal year 1995 claims of beneficiaries who were eligible for Medicaid for six months or more and were not enrolled in a managed care plan. In all, there are 17 "resource adjusted categories," 9 for beneficiaries in the

low-income women and children Medicaid population, and 8 for disabled beneficiaries. Separate rates were developed for neonates, persons with AIDS, and mothers eligible under Medicaid eligibility expansions. A supplemental payment is also made upon the birth of a child.

Maryland also developed adjusters for age, gender, and place of residence. These determine payments for beneficiaries without six months of Medicaid claims history, including newly eligible beneficiaries, beneficiaries who were enrolled in HMOs, and neonates. Interestingly, although the place of residence adjustment was made to reflect substantial differences in costs between those living inside Baltimore City and those living in other areas of the state, the discrepancies were found to be inconsequential after the ACG adjustments were made.

Colorado. Colorado has had a sizable voluntary enrollment into full-risk managed care plans by Aid to Families with Dependent Children recipients and people with disabilities. Approximately 20 percent of disabled beneficiaries are enrolled in such plans, and two plans enroll a total of approximately 85 percent of those individuals.

The impetus for risk adjustment grew out of a perception by managers of both of these plans that their organizations were experiencing adverse selection. One plan, Colorado Access, enrolled a particularly high-cost population through its university hospital and children's hospital, producing average expenditures twice those of the population as a whole before they enrolled in the plan. This led to an interim risk adjustment system based on prior expenditures of beneficiaries who switched into managed care plans: payments for disabled beneficiaries in 1997 were based on enrolled beneficiaries' 1995 fee-for-service expenditures.

Colorado has now implemented the DPS to adjust managed care rates for disabled beneficiaries. This system predicts costs more accurately for this group than the ACG or DCG system. To implement the DPS, Medicaid staff collaborated with state health plans and helped collect the encounter data needed for diagnostic risk adjustment. The plans submitted sufficient 1996 encounter data to enable the computation of adjusted payment rates for 1998.

State Employee Health Plans

State agencies other than Medicaid programs have also pursued strategies to limit risk selection and adjust health plan payments. The administrators of state employee health benefits plans are well aware of the danger that risk selection will increase their costs. Even so—and despite the fact that most states collect cost and utilization data—relatively few public employee benefits plans employ sophisticated risk adjustment methods.

Twelve states, or one of four, claim to adjust premiums within their public employee health benefits programs to reflect risk selection. In most cases, the adjusters are limited to the age and gender of enrollees: Virginia, for example, uses a prospective age/gender adjustment and calculates an end-of-year adjustment for plans with actuarially higher or lower risks. California and Washington use somewhat more sophisticated adjusters.

California Public Employees Retirement System (CalPERS). One of the largest

public employee benefits administrators, CalPERS uses demographic risk assessment in its rate-setting process. Rate targets are used to negotiate premiums with health plans. These targets are not "hard and fast" and are not released to plans before they submit bids. The extent to which premiums reflect the assessments, therefore, is not clear. Also, neither employee nor employer contributions are adjusted to account for risk differences. CalPERS and other employers who use similar methods do believe, however, that risk assessments improve their ability to negotiate successfully with health plans.

Washington State Health Care Authority. Washington's benefits program for public employees has used a risk adjustment system that incorporates demographic information and is now in the process of phasing in a diagnostic-based system. Early in the development of the new system, researchers at the University of Washington, led by Carolyn Madden, used data from six health plans to test three risk adjustment models: Diagnostic Cost Groups, Ambulatory Care Groups, and chronic disease scores. The research team now is implementing a prospective payment system based on a variant of the DCG model. Plans began to be paid under the new system in January 1998.

Before implementing the new system, the authority identified 23 areas in which detailed analysis would be needed, including the use of inpatient and/or ambulatory data, confidentiality and data security, nonstandard plan design, gaming, audits, cost of implementation, geographic variation, and outlier hospital payments. The use of ambulatory data, in particular, caused concern because of the difficulty and unreliability of data collection. As a result, the authority decided to adjust payments in 1998 by only plus or minus 2 percent, based on differences in risk measured by the DCG system. In the year 2000, plan payments will be fully adjusted using the DCG model and demographic adjustment will be phased out.

State Insurance Pools and Purchasing Cooperatives

In the early 1990s, a number of states created agencies to facilitate the purchase of insurance by small employers. Many of these efforts were subsequently repealed, but insurance pools continue to function in New York, California, and Washington.

New York. New York implemented open enrollment and community rating in its small group and individual health insurance market in 1993. To protect HMOs and other health insurers from experiencing losses due to adverse selection in these markets, the state also established an insurance pool.

To fund the pool, all insurers within a geographic region make quarterly per-beneficiary payments; the pool is then distributed according to demographic information—including age, gender, and family size of employees—and the presence of high-cost medical conditions. According to Sandra Hunt, a Coopers and Lybrand analyst working with plans to revise the risk adjustment methodology, the demographic adjustments triggered some adjustments across plans. These adjusters are being phased out over the next four years in favor of an expanded high-cost condition pool, which would transfer an equivalent volume of payments. The high-cost condition pool currently makes payments of approximately $7 million per quarter to insurers covering AIDS, transplant, ventilator-dependent, and neonate

patients.

Health Insurance Plan of California. Legislation in 1993 created the Health Insurance Plan of California (HIPC) to help small groups achieve the health insurance purchasing benefits of large employers. The legislation allowed the use of a prospective risk adjustment process in order to compensate participating carriers fairly.

The California Managed Risk Medical Insurance Board (MRMIB), which oversees the HIPC, has implemented a system that calculates the relative risk assumed by each health plan according to the age, gender, family size, and "marker diagnoses" of its enrollees. Marker diagnoses are high cost ($15,000 or more per year), relatively predictable diagnoses that are associated with inpatient stays. Participating carriers submit proof of marker diagnoses using claims or encounter data or case management or utilization review records. The marker diagnosis feature is easier to implement than a comprehensive diagnostic risk adjustment system, and the data are less difficult to obtain. By agreement of the MRMIB, adjustment is triggered only when a carrier's risk is 5 percent greater than the average assessed risk of all participating carriers.

In the first round of risk assessment and adjustment, conducted in 1996, approximately 1 percent of total premium dollars were reallocated among plans. The plan that received the most favorable selection paid $11.80 per contract per month (PCPM) into the pool, and the plan that received the most adverse selection received $46.04 PCPM. In 1997, less money changed hands overall, but more plans paid or received adjustments. Of 27 participating health plans, four paid out a maximum of $8 PCPM, and one (a preferred provider organization) received $16 PCPM. The lower volume of transfers reflects both changes in premiums and the departure from the pool in early 1997 of the largest receiver plan.

Business Coalitions

Business coalitions would seem to be in an excellent position to pursue innovative health purchasing strategies, including risk adjustment: they are not governed by federal or state regulations, are not tied to the political process, often have fairly substantial financial resources, and wield considerable market power. Also, because they typically offer employees of member businesses a choice of health plans, they would stand to gain from reducing risk selection.

For a variety of reasons, however, business coalitions are rarely leaders in risk adjustment. Still relatively new, coalitions must prove themselves accountable to member businesses looking for tangible health care savings and improvements in quality. They must avoid creating "winners" and "losers" among their members, who participate on a voluntary basis. Firms with lower than average costs may be unwilling to participate in a system that involves negotiating a single rate across firms. Also, business coalition administrators often lack the authority and resources to implement change. Finally, some employers may see risk adjustment as endangering labor relations. In the employment setting, implementing a risk adjustment scheme can be costly because younger, better-risk employees tend to be paid less and are more likely to have chosen low-cost plans. For those workers, premiums will tend to rise when a risk adjustment system is

implemented unless the employer compensates by raising the contribution rate.

Ninety-six local members participate in the National Business Coalition Forum on Health, but only 45 of those are involved in health insurance purchasing, which does not necessarily include contracting directly with health plans. Some use risk assessment primarily as a tool to negotiate premiums, often by employing projections developed by a private firm (such as MEDSTAT) for a demographically similar population in a similar community. Similarly, research by the General Accounting Office (GAO) has found that large employers use relatively crude risk adjustment techniques—often only age and gender—to evaluate premiums as a prelude to negotiations. Business coalitions that are currently investing in risk assessment and associated technologies employ a range of techniques, some more sophisticated than others.

Gateway Purchasing Alliance. This alliance, based in St. Louis, encompasses a range of employers with very different risk profiles, from small retailers to the United Auto Workers, a very high user of services. Although Gateway has succeeded in implementing only rudimentary adjustment strategies, these represent a significant improvement for employers, some of whom formerly paid premiums unrelated to their demographic profiles.

As a first step, Gateway provides managed care plans with demographic information on the alliance's entire covered population. Each plan then quotes a price for an average enrollee and a standard benefit design. The premium is adjusted to reflect changes in the benefit design (there are currently 70 variations) and the age and family size composition of each employer's prior-year managed care enrollees. To determine an employer's premium, demographic characteristics of that employee group are compared with those of the entire pool.

Pacific Business Group on Health (PBGH). This nonprofit coalition of 33 public and private employers in California and Arizona is among the most sophisticated now operating. With support from a foundation, PBGH collaborated with researchers from Kaiser Permanente and the University of California, San Francisco, to develop and test several risk adjustment models: a demographic model; a model including demographics and personnel variables, such as length of employment; a model including demographics and self-assessed health status; and each of those models with high-cost cases excluded. Excluding high-cost cases was found to be the most promising strategy, but personnel information also showed promise.

PBGH chose not to implement any of the models tested for several reasons. Their research showed, for example, that models built with data from one employer or health plan did not accurately predict risk for other employers or plans, while the personnel data proved difficult to work with and the group's survey of health status had a low response rate. Administrative difficulties, such as inconsistencies in employers' use of family size and other variables, were another stumbling block in creating categories to price. Also, although the study tested models only on enrollees under age 65, PBGH believes that its risk selection problem is especially acute in its retiree population, whose members typically have a choice between Medigap supplemental coverage and Medicare at-risk plan coverage. Finally,

PBGH employers did not reach consensus regarding thresholds for triggering a risk adjustment process or acceptable variations in risk mix across plans. At the same time, PBGH's participating health plans were most interested in geographic-based adjustments, although the analysis did not reveal consistent geographic variations in cost.

PBGH also found that price variation narrowed after it began using risk data to negotiate premiums and that "overall, risk spreads when PBGH employers were pooled did not vary much across plans." Even so, PBGH continues to pursue possible demographic and geographic risk adjustment strategies and is currently examining findings that indicate that marital status and the age and sex of an employee's dependents are reasonable predictors of costs. The alliance currently has no plans to use diagnosis information for risk adjustment.

Buyer's Health Care Action Group (BHCAG). Located in the Minneapolis/ St. Paul area, this alliance consists of 28 self-insured employers, with approximately 250,000 covered lives. Since 1993, BHCAG has offered its members a self-insured point-of-service plan called Choice Plus, which includes a negotiated fee schedule with a network of providers, a standardized benefits package, and administration by Health Partners and Aetna. Member employers have the option of offering Choice Plus alone or offering multiple plans.

Choice Plus succeeded in reducing costs by 11 percent in 1993, and its premiums have increased by only about 4 percent annually since then. Approximately 100,000 employees chose to enroll in Choice Plus, and membership in BHCAG grew. BHCAG also created and continues to fund the Institute for Clinical Systems Integration, a nonprofit organization that assists the Choice Plus provider network with quality initiatives.

Although pleased with the performance of Choice Plus, BHCAG implemented a new, more competitive purchasing strategy in 1996, after analyses indicated that more efficient provider groups were, in effect, subsidizing less efficient ones. BHCAG was concerned that incentives to improve quality, service, and cost were insufficient at the network level and that consolidation in the Minnesota managed care market was stifling competition. In addition, BHCAG believed that substantial overlaps in provider networks indicated that plans were not competing on the basis of quality. The alliance hoped that its direct contracts with provider groups would create stronger incentives to provide care efficiently.

Under its new "enhanced competitive model," BHCAG contracts directly with "care systems," defined as "primary-care centered health systems with affiliated specialty, hospital, and allied professional arrangements." Any care system that meets BHCAG quality standards is eligible to participate, but primary care providers may belong to only one care system. BHCAG plans to give employees comparative information about care systems and incentives to choose cost-effective systems.

In order to foster beneficial competition among provider groups, BHCAG has also adopted a novel version of the ACG system. Networks bidding to serve BHCAG member employees are given three years of claims data on the covered population and asked to submit claims targets based on a standard

benefit package and enrollee mix. BHCAG then sets a fee schedule for each network based on its target. Claims experience is adjusted quarterly using ACGs, and the fee schedule is revised to reflect experience over the past 12 months. This adjustment process is more sophisticated than that used by Gateway because it employs diagnostic information. Although its self-insured status prevents BHCAG from recovering losses or gains from the networks, the alliance adjusts enrollee premiums based on the claims target of the network chosen.

CONCLUSIONS

State agencies and employers are just beginning to deal with the issue of risk selection, and very few are using risk adjustment at the present time. As outlined in the table, the leading methods range in sophistication from prospective diagnostic adjustment, on the high end, to risk assessment and premium negotiation, on the low end.

Surprisingly, no pattern has emerged in the types of risk adjustment being adopted by particular types of purchasers. Effective risk adjustment certainly demands a capacity for complex data analysis, and three of the five example organizations shown in the table (the Maryland and Colorado Medicaid programs and PBGH) have close affiliations with university-based risk adjustment experts. Even so, such affiliations do not guarantee implementation, while two organizations have succeeded in implementing programs without assistance from university experts. Outside funding to pursue risk adjustment is no panacea; PBGH's risk adjustment research, despite external support, did not produce a risk adjuster that has been implemented.

What can other entities, including the Medicare program, learn from the efforts of these pioneers? First, as the paucity of working risk adjustment schemes suggests, implementing risk adjustment is difficult. Few entities are ahead of the Medicare program in using diagnosis-based riskadjustment, the best method currently available. On the contrary, the majority of large purchasers of health care are less advanced than either the Medicare program or those Medicaid programs that have implemented age, gender, and eligibility information to adjust their capitation rates.

Second, some purchasers have proven that diagnostic risk adjustment systems can be implemented successfully. Health plans contracting with these purchasers have agreed to provide the data needed for diagnostic risk adjustment and seem capable of doing so. Also, less sophisticated but still valuable systems, such as high-cost condition pools, seem easier to implement than comprehensive risk adjustment systems, perhaps because they require less data and are easier to understand. Another method, the "ceding" of high-cost cases back to fee-for-service coverage, has not been tried but is similar to reinsurance and should prove relatively easy to implement.

Finally, as shown in Colorado, as sicker and disabled populations move into Medicaid managed care, the need for risk adjustment increases dramatically. The Medicare program and Medicaid agencies in particular would stand to gain from careful consideration of Colorado's experience before enrolling disabled beneficiaries in managed care plans. Indeed, the disabled population is more predictably heterogeneous than are either the low-

income women and children Medicaid population or the commercial population. As a result, implementing risk adjustment methods for disabled Medicaid managed care enrollees is particularly urgent.

Footnotes

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4 Personal communication with Deborah Freund, Ph.D., Vice-Provost, Indiana University, 1997.

5 Richard Kronick, Zhiyuan Zhou, and Tony Dreyfus, "Making Risk Adjustment Work for Everyone," Inquiry 32(1):41-55, Spring 1995. On age and gender as predictors in the private employer context, see Joseph P. Newhouse, Willard G. Manning, Emmett B. Keeler, and Elizabeth Sloss, "Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization," Health Care Financing Review 10(3):41-54, Spring 1989.

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13 The Center for Health Program Development and Management at the University of Maryland, Baltimore County, and the Actuarial Research Corporation contributed to the development of the rates. The eight health plans participating in the program were also involved in the rate-setting process.

14 Gordon R. Trapnell, "Maryland Medicaid Managed Care Program (1115 Waiver): Development of MCO Rates-Methodology," Actuarial Research Corporation, November 1, 1996.

15 The description of Colorado's program is drawn from Kronick and Dreyfus, "The Challenge of Risk Adjustment for People with Disabilities," 1997.

16 Daniel Dunn, "Case Studies of Health Risk Adjustment: What Can Be Learned from Experience to Date?" Inquiry, Summer 1998 (forthcoming).

17 Among respondents to a Lewin Group survey (40 states), 90 percent

collect cost and utilization data. Lewin-VHI, "States as Purchasers: Innovations in State Employee Health Benefit Programs," report to the National Institute of Health Care Management, April 1995.

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32 Pacific Business Group on Health, "Developing Practical Risk Assessment Tools for Large Employers and Testing Risk Adjustment Approaches in Health Care Purchasing," February 25, 1997.

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34 Dunn, "Case Studies of Health Risk Adjustment," 1998.

35 Buyer's Health Care Action Group, 1996 Annual Report.

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Date: April 12, 1999
Time: 8:50AM
Room: LOB Rooms 206-208

The Senate Committee on **Insurance** held a hearing on the following:

SB162 *establishing the voluntary small employer health insurance purchasing alliance.*

(New Title) providing for the licensure and regulatory oversight of voluntary small employer health insurance purchasing alliances.

Members of Committee present:

Senator Wheeler
Senator Fraser
Senator Hollingworth
Sen. J. King
Sen. McCarley
Senator Squires

The Chair, Senator **Katie Wheeler**, opened the hearing.

Senator Katherine W. Wheeler, D. 21:
I'll call the hearing on SB162 to order and announce that I have an uncontrollable watering eye and I've made an appointment with my ophthalmologist and I'm not really that unhappy. It has nothing to do with the way I feel I'm just apologizing for the way I look. But we are very glad to have the Governor here and welcome.

The Honorable Governor Jeanne Sheehan:
Thank you Madame Chair, Members of the Committee it's nice to be in the same shell race and I'm glad it wasn't something I said. I'm pleased to be here in support of Senate Bill 162. As most of you know I believe Senate Bill 162 will allow small business to group together to form purchasing alliances to purchase health insurance.

(Governor Shaheen continues)

This is really a bill that was, is revised from a bill that was intruded into the legislature last session. I think this is the new and improved version. The bill last session was sent to a study committee. The study committee, some of you served on, worked very hard and recommended that we pass this legislation and set-up small business purchasing alliances.

This is really a continuation of a number of the reforms that this legislature has passed in recent years. Beginning in 1994 with Senate Bill 711, which set-up small group reforms in the insurance market. In 1996 passed legislation that made it exclusive contracts on health maintenance organizations. Both of those pieces of legislation really designed to better have access and affordability for people in this State for health insurance.

I think Senate Bill 162 is another effort to do that. Much of, there's a real need I think for this legislation for two reasons right now. First of all this bill is really aimed at small businesses. And as we know small business's really provide the backbone of New Hampshire, 98% of our business's employee 100 or fewer people. Much of the rejuvenation of the New Hampshire economy in this decade has been because of the new small business's that have been grown. Much of the new employee growth has been in those small businesses.

One of the difficulties that people, we've heard by small business, have is in getting health insurance. In fact as we look as what's happened in the economy as a whole in the last 5 years or so, the number of people without health insurance has been going down rather than going up. And that's in large part do to the fact that much of the employee growth has been in small business. And those small businesses by the fear of nature have had a much greater time in offering health insurance to their employee's.

The other reason that this legislation is particularly timely right now is because with the reforms that have been passed and the growth in HMO's and Managed Care coverage in the State, has been very effective in the past several years in keeping the cost of health insurance down. We're beginning to see that change right now. And in fact many businesses in the State are seeing fairly dramatic increases in the cost of their insurance premiums.

What this small business purchasing alliance legislation would do would be allow those businesses to get together to purchase health care at a cost that would be more affordable.

(Governor Sheehan continues)

One of the interesting pieces of information, as I was doing some background reading over the weekend on this, is looking at some of the States that have formed effective alliances and seeing what the benefits in those States have been. California's experience for example, looking at one of there health purchasing alliances showed that one of the reasons they've been able to keep the cost down is because they can administer the cost of the health insurance premiums so much more cost effectively.

What they found, in California, with this purchasing alliance was that the cost averaged only about 3% to 10% for administration. Where as if you looked at the health insurance market as a whole the cost of administering plans with fewer than 50 employee's averaged anywhere from 25 to 40%. So, one of the significant saving that happens because of these purchasing alliances is that they can administer the plans much more effectively.

One of the other benefits to the purchasing alliance is that, because of their bargaining power in the marketplace, they can provide more plan options for employees. So that as we see most employers can only offer 1 and sometimes maybe 2 plans to their employees. With purchasing alliances they can make more options available to the employees within the plans.

One of the other side benefits of purchasing alliances is that they can very often help mediate disputes between employers and health plans, which has proved to be very effective. So that they serve almost as an umbersman for issues that arise from businesses. Now, I'm sure as with many of the other efforts to reform or make changes in the health insurance market, we're going to hear from people who think this would be costly, who have concerns about how this would work, who think that this is another bureaucracy. In fact it's none of those.

This will be an opportunity for private entities; the government would not be involved except to the extent of the legislation to allow the alliances to operate and the Insurance Department would be involved with great relation. I think, what options we have as a State to continue to increase access and affordability in health care. This is one of the tremendous opportunities that we have. I would urge the committee to support the legislation and allow us to give the marketplace as many options as possible to deal with price and choice issues that consumer's have.

Thank you very much Madame Chair and I would be happy to answer any questions.

Senator Katherine W. Wheeler, D. 21:
Thank you very much Governor. Are there any questions for Governor Sheehan? See none. Thank you very much. I will call on the prime sponsor Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Good Morning Madame Chair, Members of the Committee for the record I'm Senator Leo Fraser, I represent Senate District 4. I do have some prepared comments to make but before in doing so I just wanted to thank the Governor for appearing here in support of 162.

(See attached written testimony, Document #1).

That's my direct testimony Madame Chair before I; I will just tell you a few technical aspects of the bill and several people here that know a lot more of the bill after you hear from them then than you will from me. But at any rate you should understand this is a non-profit alliance regulated by the Insurance Department. The Commissioner will approve of rates and it's going to be a statewide program. There will be criteria, for qualification, to become a member of the alliance; those qualifications will be established by the Department.

The Department will also be responsible for the standardized health plan. The alliance itself will be the policyholder. The duties of the participating carrier are all in the bill. In other words what their dues and responsibilities are as far as record keeping, financial statements all of that. It's a rather lengthy bill, Madame Chair, I don't seem to over simplify it but I think, to put it in perspective, this is a good idea. I think that it will probable help the small employers and giving them a more, as the Governor suggested, an opportunity, more choices in optioning a health delivery system number one.

Secondly that I think that under the terms of the; the bill is currently written there maybe times when a small employer will be able to afford insurance, health insurance he hasn't been able to do so in the past. That concludes my testimony Madame Chair, I would be glad to answer any questions but as you now there are a number of people here, who have a lot more technical expertise on this, then do I.

Senator Katherine W. Wheeler, D. 21:
Thank you Senator Fraser. Are there any questions for Senator Fraser? See none, thank you very much. Alex Feldvebel would you like to explain the bill a little?

Alex Feldvebel - New Hampshire Insurance Department:
Sure, I would be happy to. Thank you Madame Chairman my name is Alex Feldvebel I represent the Insurance Department. We're here today to support this legislation. We were involved in the drafting of it. What I'd like to do is just take a couple of minutes to talk about the reasons why it's needed, what it tries to do and then I'd like to hand out some materials that sort of talk about the structure of the bill.
(See attached Documents #2 and #2a).

The basic reason for this bill is to address certain problem today the health insurance market operates. So it's similar to the "711" reforms that we passed a couple of years back. Let me; just mention briefly, some of the problems with the health insurance market that we think are addressed by this legislation. One of the most compelling issues is the issue Senator Fraser already mentioned to you, the consolidation of the market on the supply side.

Both insurers and providers continue to consolidate their market power and you see the market heading in the direction of "oligopoly of power" on the supply side. So, for health insurer's it's been mostly consolidating, mergers and acquisitions. We also have market departures, so for example in the smaller group market, we're down to 5 HMO's with alliance share of the market going to 3 of them.

Health care providers, what's been happening, is that Hospitals and Doctors have been busy forming members and PHO's and Mega-PHO's (PHO – Physician/Hospital Organization). For the same reason, basically to get bigger, everybody wants to get bigger. For the Hospitals and Doctors that's for the purpose of getting a better negotiating position with the large MCO's. (Managed Care Organization).

At the same time employers that from the purchaser's side of the employers market position is eroding. At the National level now, private employers pay for just 21.2% of the Nations total health care spent. That was a surprise to me when I first read that. We think of ourselves as having an employer based health care system but there's been continuing erosion in that.

Government now pays 47% of all health care spending and individuals pay more than employers, individuals pay 26%. So, 4 out of every 5 dollars spent on health care is individuals or government. So you've got a situation now where health insurers are the final power because their bigger and fewer. And health care providers are more powerful because of their hiring network.

(Alex Feldvebel continues)

Market healthcare services continue to go up as well as utilization. Therefore market forces are not very well aligned with consumers and purchaser interests. And consumers and purchasers are likely to be paying the line; we see that happening now with significant increases in the cost of health insurance. This year the increases are, in the first quarter of this year to be 35%.

Other problems with the market, consumer choice is in the middle. I recently heard a figure that nationally 60% of people with employers sponsored health insurance have no choice of health coverage. In a small group market, for small employers it's much worse, 80% of small employer's offer only 1 plan, of those who do offer coverage and only 40% offer coverage. So there's no choice. That's not good for the market if you want competition the end user, the consumer needs to have a choice.

In addition consumers don't have very good information. Even though they do have a choice they can't exercise that choice meaningfully because they don't have good information about what the plan is, what's covered. Because the products are pretty, are sometimes pretty inscrutable. So we have these things going on all of which would be addressed by the formation of a purchasing alliance for small employers.

I would like to at this point, handout some materials. So, basically this small employer purchasing alliance is intent to address this issue of imbalance in market power by letting the small employer's get together, for the purpose of purchasing as a unit and increasing their bargaining power.

I will ask you to look at this first one, it says SB162 on it, ***(Handout, see attached Document #2)*** and also to offer choice. Those are the 2 basic reasons for the formation of purchasing alliance. The basic structure is this little picture on the front. Multiple employers get together through the single entity of the purchasing alliance, which turns around and contracts, with multiple plans.

Here are the basic functions of an alliance, on the second page it list them. ***(See Page 2 of attached Document #2).***
The alliance, once it's formed, turns around and negotiates and contracts with multiple insurers. They do the Marketing of the coverage, Enrollment, Premium collection and distribution. They supply Consumers with information about the health plans. They do the Data analysis to supply the consumer with information. They also pay attention to quality and they do plan performance measurement and Quality improvement.

(Alex Feldvebel continues)

That's the basic functions the alliance performs. There are a number of things that they don't do that distinguishes from MEWA's and other entities that have existed and also looked like group purchasing.
(See Page 2 of attached Document #2)

They don't bear risk, so they buy fully insured products. They're not a self-insured entity; they don't directly pay health care providers. So they're not like an insurance company themselves. They don't market for just one carrier; they don't directly provide healthcare services.

There's an analysis in the materials I gave you which, precisely how purchasing alliances go about conferring their benefits that we're planning on. One benefit is lower costs. And there are basically 2 mechanisms beginning, bargaining on behalf of large groups for producing more group bargaining power. And also when you perform these functions of marketing enrollment, payment collection and distribution for a large group you achieve certain economies of scale and therefore can reduce the cost of coverage in that manner as well.

You offer choice simply by marketing, by contracting with more than one plan and then providing good information for "apples to apples" comparisons and you also ask the carriers to offer their benefits in a standardized format. So, you define, like the 3 or 4 most popular plans, coverage options and the carriers all offer their coverage according to that standardized format. So you end up being able to produce minimal marketing materials, that some of the purchasing alliances have used.

I'd like to get these back, but there's one from Colorado, California and Connecticut. They basically layout a pretty easy to read format of what the options for coverage are. And you can easily comparison shop for price and quality. So the basic idea is to get insurer's peak based on value and not such things as risk selection. We don't want insurer's competing on who can get the healthiest groups. We want them competing on who can offer the best product at the best price.

And by bringing employers together and setting up the purposing through mechanisms like that, what you get is competition based on value. You also enhance quality because quality becomes more of a factor to the consumer. Because the consumer has choice and the consumer is well informed as to what he or she is buying.

(Alex Feldvebel continues)

I wanted to mention that there's sort of an outstanding issue about the way this legislation should be structured. This came up over the summer in the study committee and was discussed last year. The question is whether the legislation ought to allow for more than one purchasing alliance in this State. And I think it's very possible that it would be a good idea to do that. And I just wanted to let you know that that issue has been out there. That the legislation could be, that you have before you, contemplates "one person alliance" only.

The reason for going for a one-person alliance is you want to get bargaining powers, in a small State like New Hampshire you may have one small employer purchasing alliance. The, I think, would is there to recommend multiplies? Well in a situation when the State is not it's self putting up the money for the start-up cost for this organization, which we're not planning to do in this legislation, I think it could make sense to allow for more than one.

And have the oversight function of the Insurance Department be in the form of certifying these things. So any group that meets the right qualifications in the Legislation can come forward, ask for certification and if they are deemed to meet the requirements they'll get certified.

So I think there is some sense to that and that's an issue that's still outstanding. The Insurance Department would be happy to work with the Committee if you felt it was a good idea to change the Legislation to allow more than one purchasing alliance. That could be done relatively easily. The Legislation you have before you is based on a NAIC model. There is more than one model. One of the other models is this concept I have just been talking about that would allow more than one small employer purchasing alliance in this State. I'd be happy to answer any questions.

Senator Katherine W. Wheeler, D. 21:
Any questions? Senator Squires.

Senator James W. Squires, D. 12:
I have a question about you're statement that 4 out of 5 healthcare dollars are spent by Government and individuals. Would you not agree that while that may be true for a Nation as a whole, you look at the population being served by an environment like this, which would be non-Medicaid working people up to 65. That there's a much higher fraction of employer contribution in that group then there maybe nationwide?

Alex Feldvebel:
Oh, yes. This Legislation is aimed at employer sponsored health insurance coverage. The only point I'm making in siting that statistic is that there is; employers need help there's been an erosion that the market forces have been pushing, have been really squeezing the whole institution of employer sponsored coverage. And it's in danger of getting too weak that's the only reason I'm making that point.

Senator James W. Squires, D. 12:
So then it's your assertion that the heart of this bill reduces the cost to employers?

Alex Feldvebel:
It makes it easier for small employers to offer coverage. They are not in good position to contract nor negotiate like large employers. It through greater bargaining power it offers a price advantage, not necessarily a great pricing advantage, but a marginal, comparable price advantage.
(Alex Feldvebel continues)

And allows the small employer to offer choices, something almost no small employers can now manage at this point and time. So, somewhat of a price advantage, offering choice and a lot less hassle to the small employer in offering a reduced sign-up.

Senator James W. Squires, D. 12:
Would you agree that in certain parts in the State, particularly to the north, why you may conceivably offer coverage choice, the fact is it's difficult to offer provider choice because there's a very limited number of providers in the first place? So, in fact that's somewhat to New Hampshire that even though you have multiple plans you have fixed number of providers? So you're not in fact offering provider choice your simply offering more of a plan choice?

(Tape Change)

Alex Feldvebel:
So any plan choice couldn't give you provider choices that you won't otherwise have.

Senator Katherine W. Wheeler, D. 21:
Further questions Senator Squires?

Senator James W. Squires, D. 12:
No thank you.

Senator Katherine W. Wheeler, D. 21:
Further questions from the Committee for Mr. Feldvebel? Senator McCarley.

Senator Caroline McCarley, D. 6:
In terms of the concept they adopt the fact that it would be possible to have several alliances rather than simply one? In a State of this size is that a, do I assume that this model will show that because that doesn't seem to be quite the same kind in the State of our size?

Alex Feldvebel:
Right. You need a certain size to make these alliances able to deliver the benefits that we're talking about. It would be like 20,000 (someone from the audience states 20,000 is the critical threshold), maybe less but you need, that's fairly a significant number and it would be hard for to have. Multiple alliances are able to get that kind of enrollment. On the other hand if you let anyone who meets the qualifications give it a shot maybe you'll have a better chance at having one of them succeed. So that's sort of the thinking of allowing for multiplies.

Senator Katherine W. Wheeler, D. 21:
Senator Hollingworth.

Senator Beverly A. Hollingworth, D. 23:
Alex, last year there was sort of, the Senate passed it and I know the House had some problems and it was, it seemed that some the argument that they had against it was they were afraid that it would cut into they're market. Now there is no exclusion is there so that, if somebody offered a good plan, one that has choices and one that's within the market, price market, would there be no reason why they couldn't be in involved in the alliances, is there?

Alex Feldvebel:
Yeah. Who's the they?

Senator Beverly A. Hollingworth, D. 23:
There were a couple who came before us and testified, HMO's and the insurance groupies that came in. I could never understand and I guess I'm asking you to help me understand why they would oppose this if they write for this can't they? We aren't excluding anybody from being involved in and being selected if they the right choice and the right price?

Alex Feldvebel:
The reason for the Legislation is that the alliances are suppose to offer as much choice as possible. So it should contract with a large array of plans to offer as much choice as possible. Yet the companies that expressed concern I don't think, it hasn't been expressed to me that there're concerned about being closed off. We have a lot of the good quality carriers in the State. What was expressed to me was fear that the way they market now, they basically sell to the employer and they get the whole group.
(Alex Feldvebel continues)

If the alliance exists like this they wouldn't necessarily get the whole group. They might get some of the people. There's a group of small employers say 10 people they might get 3 and they prefer to get the whole group, they prefer to deal with the employer not the employees. That's one perspective up north the consumer's need to have choice and they don't get very much weight.

Senator Beverly A. Hollingworth, D. 23:
Follow-up question. Can they then pick companies who have healthy employees, rather than wait for all small groups were involved? Say you might have one that has older employee's or young women who maybe pregnant so that they can say we're going to select this company because it's what we know to be a good, almost like a "cherry" type group?

Alex Feldvebel:
I believe that still goes on to a certain extent. We address a lot of the risk selection with the "711" reform with regards to rating health, health underwriting, health based underwriting. But you can do risk selection in this market. You do it mostly through benefit design. So you structure your benefits so it looks less attractive to say people more affected health people. More through marketing, the way that you market.

(Alex Feldvebel continues)

You can emphasis healthy people. So there's a lot of evidence that that kind of risk selection still does go on through those two mechanisms plan design and marketing. And the existence of a purchasing alliance will help prevent that and also if the person wants to exercise the option to adjust their risk and therefore compensation the plans that aren't giving risk selection and getting more sick people. It sort of eliminates that market incentive to risk select and what (inaudible) gets is competition based on value.

Senator Katherine W. Wheeler, D. 21:
Thank you. Senator King.

Senator John A. King, D. 18:
What is the dedication of the, either the companies that are going to be involved or the health agencies. Can the leave anytime they want? Can they change from one to the other in same lines, what is there for stability as far as that's concerned?

Alex Feldvebel:
The companies?

Senator John A. King, D. 18:
The companies and the employees that are going to be involved and the employers, can they back out at anytime they want to?

Alex Feldvebel:
The companies can back, they have to give certain notice, I think it might be 90 days before the back out. Then, I don't know, if they want to come back in I don't know if the Legislation address that issue or not. Employers can back out as well. There is some provision in the Legislation about if they backed out can they immediately get back in? And there's an issue there as well but I'm not sure. That's something I need to address with an amendment because the Legislation currently allows, says if an employers back out they may have to have a waiting period before they can come back in. I'm not sure that's consistent with our guarantee issue law. So that's something we still need to pay attention to. So there are certain restrictions but basically an employer can come in or back out and the plans can come in and back out.

Senator Katherine W. Wheeler, D. 21:
Senator King.

Senator John A. King, D. 18:
So it's all voluntary? That's even for the companies? If they don't want to join up and end up with an alliance there's no cost?

Alex Feldvebel:
Yes. You can start one of these things and the company could boycott it. They could say "we don't like this kind of thing" and we don't want to let it happen. That's been attempted in other States and generally they seem to, if they are setup properly they seem to work. The companies don't want to miss the opportunity of that business.

Senator Katherine W. Wheeler, D. 21:
Any further questions for Alex Feldvebel? See none, thank you very much. I'm going to call on John Bresler now and then I'm going to start alternating testimony.

John Bresler – Suncook Trim Corporation:
Thank you Madame Chair I appreciate the opportunity to speak early. As I look around the room I may be the only employer here and I sit here and discuss this bill the question in my mind is who's watching the store so I would like to get back to work. I came before the Committee last year but I didn't get the chance to speak because I had to leave after a couple of hours, so once again thank you.

I want to thank Senator Fraser. In his district is Pittsfield Weaving, I run a similar business in Suncook. I also wanted to thank Senator Trombly, who I spoke to over the weekend, as co-sponsor. I said people do not realize that the health care cost is a bigger single increase. Therefore a bigger problem for our employees and our bottom-line many of the tax issues going through the State.

We recently did our purchasing processing. We had Harvard, Tufts, Matthew, and Healthsource, who was our supplier. The smallest increase we were able to limit our new contract to was 35%. Having roughly 50 employees and revenue slightly over 4 Million in 1998 I can tell you the cost of our health care in 1998 was 2 ½ of gross revenues.

(John Bresler continues)

And with the increase of, that was roughly $104,000.00 in checks that I wrote to Healthsource. And this year our bill came in, the lowest bill we could get was $139,000.00 for the same services. So once again that $35,000.00 increase is a lot more than the BET, the BPT and any other group of taxes that were coming up.

What I would like to simple lay out, it will take about 5 minutes, and I will finish this competitive model for business. 2.9% of unemployment the greatest need is to recruit, hire, train and retain good employees. It is basically impossible for us to retain high quality employees when benefits are the issue.

Over the last 4 or 5 years since NAFTA we have had the competitive nature of our business has changed. In a non-intuitive way in that we have seen many companies from outside the United States come in and open-up new businesses in our business. People from China, Columbia, Argentina, Iran basically with NAFTA, everybody recognized you have to be in Canada, Mexico, the United States to sell our markets which are deplored in the world.

Specifically we have competitors in New Brunswick in Eastern Canada that brought in firms from China. They currently pay an industrial rate. Canada pays for the health care, the current wages are about 20% less and with the Canadian dollar they can essentially ship-in freight prepaid at our manufacturing costs. So we certainly now what competition is and if we are the "Canary in the coal mine", I would suggest to you folks here that manufacturing is not a given.

So, we look at what is the contract between us and our employers. Essentially we feel that to provide at least catastrophic health care is something we must do. And in return for our risk and our possible reward we're going to make the money, they're going to do the work. They deserve to have the knowledge that they can have their kids and themselves covered.

Under the new increases, specifically, for some reason single moms are the ones who get hit. And there's a big cost to society there because the incentive for them is to go back on welfare to get the health care. So we see people struggling to have day to day, go to work, pay for their health care and their not asking for much.

(John Bresler continues)

So, I would say to you again, to follow what Senator Fraser said, it's a good idea. I think for many of the insurance companies, the argument that I hear, is somewhat circular. Which is it's a bad idea because it won't work because it's a bad idea. I think that if they felt their revenues would go up under this plan, they'd think it's a good idea.

It's not simply the insurance companies who are at fault certainly there's the whole issue of health care and the delivery of health care and the cost of health care. Let me just ask a question and I didn't see it in the bill. And that is, is there any sense that this is a high cost option for the State of New Hampshire? I don't think it is.

I think that in a "state of flux" certainly now as we know our tax structure is in a "state of flux". Anything that government can do to create a competitive advantage for small business who employs more than 50%, sometimes 75% of everyone in the country. Gives us the opportunity to higher, train and retain good employees by providing them the basic, simply health plans at a reasonable cost.

My final suggestion might be this and I'm not sure it makes sense to you in-light of the bill but I will offer to you. There is no suggestion that there is any cost to companies for being involved in the alliance. For my personal point of view there's a great benefit to spreading the risk of analysis the plans. And the "apples to apples" situation is the hardest for small companies.

It takes one fulltime person about 3 months to spreadsheet and understand the differences, the little hooks, that the varies company put in or things you didn't know was a trap door that you only find out later because you were focused on the cost. Your focused on trying to make a profit and you don't have the time to figure out this ones hospitalization is better than this ones but over here you get a better prescription plan. There's got be an economy of size in this alliance. I'm paying for people to do this fulltime.

If 4 or 5 companies could get together, there's defiantly a cost savings. And perhaps the businesses in the alliance could bare some percentage of the cost because they certainly get the benefit in either cost reduction and/or better benefits for their employers. That's basically my position and I very much appreciate the opportunity to share it with you.

Senator Katherine W. Wheeler, D. 21:
Any questions for Mr. Bresler? See none. Thank you very much for coming and testifying we appreciate your time. David Larrivee, from Tuft's Health Plan wishing to speak in opposition to the bill.

David Larrivee – Director of Market Relations, Tufts Health Plan:
(See attached written testimony, Document #3).

Senator Katherine W. Wheeler, D. 21:
Any questions for Mr. Larrivee? Yes, Senator Hollingworth.

Senator Beverly A. Hollingworth, D. 23:
Yes, Mr. Larrivee do you have a copy of your speech?

David Larrivee:
Yes I do and I would be happy to leave it.

Senator Katherine W. Wheeler, D. 21:
Further questions?

Senator Beverly A. Hollingworth, D. 23:
Yes. Do you write for any States or does your company write for any States?

David Larrivee:
To my knowledge Maine is the only one where there is a current Statute passed or actually in place.

Senator Katherine W. Wheeler, D. 21:
Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Mr. Larrivee first of all I totally disagree with you that this may not reduce cost. I don't know and I don't think you know either whether that's a fact or not. That's not a question that's a statement, I apologize for that. I will ask you a question.

(Senator Fraser continues)

I assume that if Senate Bill 162 is enacted and the Governor signs it that Tuft's Health Plan would not be one of the participating carriers? Is that a fair statement?

David Larrivee:
I think we'd need to evaluate the specifics of the Legislation that actually gets passed. There are certain components of this that make it very difficult I think for us to entertain participating, although we are committed to the small group market place. The small group market place makes up more than 80% of our total business in the State. That's the way the State operates, is the small employers as other people have mentioned. So we would want to be at the table as it relates to small employers, it's that that it's viable to us.

Senator Leo W. Fraser, Jr., D. 4:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Further questions? Senator King.

Senator John A. King, D. 18:
You said there was 89%?

David Larrivee:
In policies, I believe.

Senator John A. King, D. 18:
Where, what states we're they?

David Larrivee:
In this State, in the state since the small employer accomplishments there's been a dramatic increase in the number of policies, small group policies. I can tell you that just from a personal experience at Tufts Health Plan. We've seen over 5,000 new small employers with an average size of 2.

(David Larrivee continues)

Meaning a lot of small employers, some of them I think probable were in the individual market, have become part of the small group market because they are licensed businesses and because the current legislation allows us to offer a competitive package which they can compare, use brokers and agents to do so and to increase the best value for their dollar.

Senator Katherine W. Wheeler, D. 21:
Further questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Mr. Larrivee is it a fair statement that Tufts Health Plan vigorously opposed 711 when it was being legislated.

David Larrivee:
No, I believe actually we we're not in the State at the time. This was back in 1994; we were licensed in 1995. So we were not part of that.

Senator Leo W. Fraser, Jr., D. 4:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Any further questions? See none. Thank you very much. Karen Hicks has asked for a minute or two to be able to explain something.

Karen Hicks – Governor's office:
Thank you Madame Chair, I really only want to take one minute to address something Alex meant to speak too in his explanation but David also reminded me we need to address this.

One of the issues the opponents of this Legislation have raised is the whole idea of risk segmentation in the market. I want to say that, first of all that is obviously not the intent. The Governor is a strong proponent and protector of the small group and individual market reforms. And we really kept that in mind when drafting this Legislation. It is meant to take the next step that we started on when we enacted the reforms.

(Karen Hicks continues)

The alliance would have to play by the same rules as everybody else in terms of community rating, guarantee issue, all of those things. Which really apply to the insurance side of this. This enables small businesses to come together. It will not allow the purchasing alliance to prohibit any company that wants to from joining, so long as they adhere to the group size. So, I just want to get that out on the table right now, it's something people have raised over and over again. I just think the argument doesn't have any merit.

The second thing that I wanted to address is one of the issues that the Legislature thought was very important in the enactment of Senate Bill 711 in 1994 was the need to really increase the predictability of health insurance prices for small business. I think over the, certainly the Legislation helped to do that, but one of the things we've seen over the past 3 or 4 years is intense competition in the health insurance market. Where many companies purposely chose to under-price their product, write the product at a risk and now I think we're seeing, in the so-called market adjustment, them exacting their price for that under-pricing.

One of the things the health insurance purchasing alliance would do is even-out competition so that we don't have this phony competition. We don't have significant under-pricing only to have carriers get a significant share of the market and raise prices again. It will help keep downward, consistent pressure on premiums so that it's more predicable for small businesses. They need that level of assurance and predictability. So I just wanted to address those two issues. Thank you.

Senator Katherine W. Wheeler, D. 21:
Any questions for Karen Hicks? Senator Squires.

(Tape Change)

Senator James W. Squires, D. 12:
I just realized, until I read this report here. That if the alliance is going to define a set of standardized health benefit plan?

Karen Hicks:
Right.

Senator James W. Squires, D. 12:
Does that mean that the alliance will decide on a benefit plan, will decide if a benefit is covered or not covered?

Karen Hicks:
The alliance would come up with a standardized benefits package. The reason for that is so that companies can actually compare "apples to apples". And so there won't be just one benefit offered but rather, if it's functioning properly, you could have a minimum of 3 carriers offering as many as 9 different products. So the goal in that is to really facilitate comparison so that we have competition not only based on price but also based on value.

Obviously, because it's purchasers who would be driving the benefit selection rather than those offering it, I would assume they're really going to keep an eye on cost since they're footing the bill. The other compelling reason I think that's linked to that is one of the things Rick Curtis, who's a expert nationally on health and has put these things together. One of the issues that he spoke to that I think is very compelling is that this will stabilize coverage for the employees.

Since small businesses who are offered health insurance are so cost sensitive they're in and out of the market with very short turn around because of a 10 or 15 or 20% cost increase tips it over the edge. So one of the ways this helps to decrease the number of uninsured is allowing employers to offer a contribution. So if the baseline price for a product is $150.00 the employer can choose to pay only $130.00 and the employee can make up the remainder and have greater choice.

So if they want to choose up they can add their own dollars in and experience the benefit of that choice. Not only will it allow families to have one health plan where as right now both parents are employed by a small business they can be in as many as 2 or 3 health insurance plans. It will allow the families to stick together but also help to stabilize it. So that they're not being driven so much by the cost sensitivity but with they're own resources they can help provide some stability there on.

Senator James W. Squires, D. 12:
You think that you or the Insurance Department could obtain an example of this?

Karen Hicks:
Of the standardized benefit product?

Senator James W. Squires, D. 12:
Yes.

Karen Hicks:
Certainly.

Alex Feldvebel:
I think it's those booklets that are in your binder.

Senator James W. Squires, D. 12:
I guess I; just a follow-up. If there is such a concept if it's consistent, I'm not sure the Legislature couldn't require the Insurance Department to develop such a plan. And then make sure each carrier offers it among their other offers. I don't know why we would want to single out a new corporation to define a benefit plan. I understand it in an Indemnity setting that's sort of what Medicare does. There is a set of benefits and everybody has to live by them. But in a Managed Care setting a standardized set of benefits being offered by every plan is something I want to see.

Karen Hicks:
Senator Squires it is my understand that right now that many employers choose they're own benefits plan, this in this out, based on what the needs of they're employees are. And so what this would simply do is extend that to the Health Purchasing Alliance about the member employers to really have a lot of input into what those benefits packages look like. Rather than having the plans dictate, which they do for small businesses I don't think that small businesses currently have the market power or clout to really alter the benefits plans to the same extent their large employer/counterparts do. And so I think that again this is trying to provide some equity in the market between large and small employers.

Senator Beverly A. Hollingworth, D. 23:
(Senator Hollingworth has temporarily taken the chair)
Further questions for Karen Hicks? See none. Thank you. Bill Bartlett.

William Bartlett Jr. – S&H Murphy:
Good Morning Madame Chairman, Members of the Committee I'm William Bartlett from S&H Murphy we represent Harvard Pilgrim HealthCare. With due respect to the Governor we formally appear in opposition to SB162. I have a prepared statement by Tom Gough who is the Director of New Hampshire Operations and Development.

(See attached written testimony, Document #4).

Senator Beverly A. Hollingworth, D. 23:
Thank you. Any questions for Mr. Bartlett? See none, thank you.

Senator Katherine W. Wheeler, D. 21:
George Bald.

George Bald – Department of Resources and Economic Development:
Madame Chair, Members of the Committee, Good Morning my name is George Bald, Commissioner of the Department of Resources and Economic Development.

(See attached written testimony, Document #5).

Senator Katherine W. Wheeler, D. 21:
Any questions for Commissioner Bald? See none, thank you very much for coming. Harold Sullivan.

Harold Sullivan – NHALU:
Thank you Madame Chairperson, my name is Harold Sullivan I'm the Legislative Chairperson for the New Hampshire Association of Life Underwriters. We're approximately about a 600-member organization of agents and brokers producing life and health insurance in the State of New Hampshire.

In contrary to what the gentlemen said before many of our members are self employed individuals who do provide for their own employees. It effects us in 2 ways when this type of legislation comes in. As the Govern said this is Legislation that is very similar to SB494 which was proposed last year. Many of you know we opposed that bill and most of our concerns continue with this bill.

(Harold Sullivan continues)

The only significant improvement we see is that now this would be supervised by the Insurance Department rather than the Department of Health and Human Services, which is an improvement in the Legislation. However the rest of the concerns remain unchanged.

Our associates with the health underwriters will give a more specific testimony of our concerns so I won't duplicate their testimony. But I would just say that not much has changed since last June. I don't think the State of New Hampshire has grown any larger, not that large of an increase in population.

It's been shown in other States that these Purchasing Alliance work best in large States with significant pools to bring together so there is some economy of scale. I think you would need to involve the entire small market. Pulling the whole small group market into the alliance if you're going to work this alliance efficiently. As Senator Fraser said you haven't proved there's any increase in cost but we haven't proved there's any decrease in cost either. So our concern from last year remains unchanged. Thank you Madame Chair.

Senator Katherine W. Wheeler, D. 21:
Thank you. Any questions for Mr. Sullivan? See none thank you for coming. Jonathan Stuart.

Jonathan Stuart – North Country Health Consortium:
Good Morning, Madame Chair, Members of the Committee. I'm Jonathan Stuart I represent the North Country Health Consortium, which is a collaborate of 10 Health and Human Service Organizations providing health care services north of the Notches. I'm here today to speak in support of Senate Bill of 162. I have handed out a prepared statement and summary, which I will go through for you.

(See attached written testimony, Document #6)

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Any questions for Mr. Stewart? See none thank you for coming to testify. Lori Real.

Lori Real – Director of Planning and Research, DHHS:
(See attached written testimony, Document #7).

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Any questions for Ms. Real? Senator Squires.

Senator James W. Squires, D. 12:
Lori, your statement about choices certainly has to be true but I keep coming back to the cost question. And if you were to ask the question in a particular manner, does an employee want more choice and willing to pay for it them selves you might get a different answer.

My question is health care cost fundamentally; I relay it to the benefit structure, despite all of that about administration the fact remains that the driver in health care cost is the benefits.

So my question is why do we need an alliance to define a set of benefits? Why would it not be just as possible to say the Insurance Department who know more about benefits then seems to me a newly created alliance you will design a baseline set of benefits and compel every carrier in New Hampshire to offer it. Then you know whose claims are whose. What is the advantage of doing it this way?

Lori Real:
I think that the Department of Insurance is very capable of doing that but the New Hampshire way is less Government proposing and complying and mandating then it is involvement from the community and the employers. And that they employers participate in that development where they'll feel that they better understand what their employees needs are. Then they will be more likely to enter into a purchasing alliance than if it was mandated. I think it's that philosophical involvement.

Senator James W. Squires, D. 12:
That elusive New Hampshire way, thank you.

Senator Katherine W. Wheeler, D. 21:
Yes Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Lori would you agree with me that in all likely hood that using the same standardized product that in all likely hood an employer, a small employer with 50 employees goes to market, he in all would probable get a higher price for his product than if there's 5,000 members to insure? Is that a fair statement?

Lori Real:
People from the Insurance, I think, industry could speak better to that than I but my past experience on the insurance side of the market is that it does cost more administratively for small groups individually than it does for large groups.

Senator Katherine W. Wheeler, D. 21:
Any further questions? See none thank you very much. I have a card for people who do not wish to testify. Paula Rogers has signed up in opposition and has submitted written material. ***(Each Senator received their own letter).*** Katharine Eneguess has signed up in support, representing BIA not wishing to testify. Senator McCarley signed up supporting the bill not and not wishing to testify. Tom Harte wishing to testify in opposition.

Tom Harte – NHAHU:
Good Morning Madame Chairwomen, Committee Members my name is Tom Harte and I with Landmark Benefits Group in Salem New Hampshire. I have submitted written testimony, which I hope you have time to review. ***(See attached written testimony, Document #8).***

But instead of me reading from my testimony I will talk to you about a few points I've heard today that I wanted to provide verification for. The organization I represent today is New Hampshire Association of Independent Insurance Agents and also The New Hampshire Association of Health Underwriters.

The first thing I want to talk about is who is the broker? I've heard some people come up today and talk about different roles that the alliance would perform, different roles the Department of Insurance would perform. But I run a very small practice in Salem. We have one employee who represents maybe 20 small employers in the State of New Hampshire and thousands of our insured population.

(Tom Harte continues)

My job everyday is to go through those spreadsheets from that gentleman who comes from Suncook. My employer clients don't need someone working fulltime for 3 months to shop all the different benefit in the State of New Hampshire and all the plans that are within those companies.

My job is to do the people who work for me, that is our job to do that and in addition to the shopping that we do, as that gentleman referred to it, we take care of consumer complaints, everyday. That instead of going through the Department of Insurance, consumers advocate, we take care of that for them. Not only can we perform those tasks we take care of full Cobra compliance; we take care of take-over benefits. We insure that the provisions of the Federal Government are protected. We make sure that if the employer has questions regarding provisions we take care of them right there.

So instead of passing that over to the Health Insurance Purchasing Cooperative we would take of ourselves and for what a very, very, low fee. We are aloud to charge fees in our practice, but we do not charge fees, we solely take commissions from Health Insurance Companies. We take care of benefit education, marketing, we do the physician matching.

Before we even go into an employer, especially a small employee less than 10 employees, we go to the employees and ask them who your PCP? If you had a choice of a hospital to go to what hospital would that be? One of the best things that has happened over the past couple of years, since Tufts Health plan and Harvard and Blue Cross has improved their benefits in Mass, Mathew Thornton and other plans, we have access to Boston facilities.

We have excellent hospitals in the State of New Hampshire who have had person problems in members, where as there is a lack of coverage amongst the hospitals. So our insured population if they feel better about it have full access to Boston Hospitals where as prior to 1995 with the health plans that were in the State at that time, to be very difficult to do so.

Now I will talk about consumer choice. Last year in August, Legislation was passed that prevented any employer who had 3 employees to offer more than one health plan. There's a 37-½% requirement for employee participation and in the event a 3-person employee wanted to over 2 medical plans they can not do it. It's impossible to do it, you have 2 employees choice 1 health plan the other employee choices the other health plan, because their physician is in there, they can't do it, 33%.

(Tom Harte continues)

So, that's been a huge challenge for us in the past year. And in certain situations you have a 10 person employer and only 1 or 2 people want to have a Blue Cross policy and everyone else wants to have a Harvard plan, you can not do it, it's impossible. So, the Legislation historically has shown that employee choice is not a big a concern to Legislators as are other concerns.

But it's a concern for us, the Health Underwriters, the Life Underwriters, the Insurance Agents and our consumers, want to have that choice. Do we need to go to a Health Insurance Purchasing Cooperative to do so? I don't think so. I think that the repeal of the 37 ½% requirement is a huge step in the right direction to provide employee choice and consumer choice.

Even the State of New Hampshire, the State of New Hampshire in a recent decision to have their own medical plan the took one medical plan. They didn't have to choose they could have chose 2 or 3 or 4 medical plan that are insured in the State. They chose one; there is a reason for that, I can't tell you what the reason was.

But it kind of disturbs me that the State of New Hampshire in a purchasing made one health care decision for all their employees as opposed to just one. I know that members of the Department of Insurance don't appreciate that as well, they'd like to have some options.

The comparison between other States, Colorado, California and Connecticut and looking at the State of New Hampshire, New Hampshire is one of the healthiest States in the country. They also have the best medical insurance plans available to employers and consumers. If you look at, use Newsworld report back in October or Newsweek, I presented you with those articles; we have the absolute best health insurance plans. We have the best access to physicians, the healthiest State. So we can not compare the demographics or the characteristics of the State of New Hampshire to those 3 other States.

And if it works in those States does that necessarily mean that it's going to work in our State? I don't think so. It may, I don't know, it could. But that's the big question everybody is saying today, it might work but we're not sure. Nobody can give us any guarantees. One of the real interesting concepts I'm thinking about as I'm sitting back here is that the Department of Insurance and the Governor's office, I thank them very much for making a stand to include brokers and agents in this bill, because last year it was questionable, are brokers going to be considered in this bill? It changed earlier this year to include brokers and agents.

(Tom Harte continues)

And I'm still sitting here today, even though that I know that I can be paid and compensated for it and health plans know that they can possible increase their market penetration, but we are still opposing it. Not because I don't think that I'm going to get paid and that I'm going to be compensated fairly or that the health plan is going to increase their market share but rather because we think that it's not going to work.

That the Alliance is not a necessary component of the health care marketplace in the State of New Hampshire today. If I could make my life easier, I have 3 little kids; I want to be home with those kids as often as I possible can. If it makes my life easier it can make the lives better for my consumers and my clients I would love to do it.

But I don't think that the lack of employee choice as it stands today, there is a reason for the 30% rate increase that we've seen. I don't like to see it, I don't like going to my employers and saying, "here you go, here's a 35% rate increase". Those are other problems, those are other health problems that we have across the State, with the hospital competition and prescription cost increase of 16% over the past year. I think the individual health care is a larger concern than trying to focus on a Health Insurance Purchasing Cooperative.

The North Country, another gentleman brought that up, I think that's a problem. But Tufts, Harvard Pilgrim....***(Tape Change)...end of testimony.***

Senator Katherine W. Wheeler, D. 21:
Thank you, any questions? Senator Hollingworth

Senator Beverly A. Hollingworth, D. 23:
You said you could charge fees for your services but you don't you take the cost from....., I didn't hear what you said. How do you...?

Tom Harte:
I solely get compensated from the health plans.

Senator Beverly A. Hollingworth, D. 23:
So the health care plans they increase their cost so that they can provide to re-coop they salary.....

Tom Harte:
That's not necessarily true. Health care plans today when they file their rates with the Department of Insurance include a component of compensation for brokers and agents.

Senator Beverly A. Hollingworth, D. 23:
But that does in fact, the cost, include the cost delivering health care?

Tom Harte:
It does, but under the HCPC plan the same rules also apply.

Senator Beverly A. Hollingworth, D. 23:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Any further questions? Senator Squires.

Senator James W. Squires, D. 12:
The testimony before, the individual who I think ran a manufacturing firm, alluded to the necessity to clean the house as it were to exam all these plans. But what prevents him from hiring you, or somebody to do that for him?

Tom Harte:
Excellent question. As I said before I have a very small practice and our clients really appreciate the work we do for them. Most of our clients don't go out to bill to all other health insurance brokers through the course of the year because we do a really good job for our clients. I think for that gentleman, if I could had him a business card and say my name is Tom Harte from Landmark Benefits I can save you time, we can do that job for him he just needs to find the right person to do that.

Senator Katherine W. Wheeler, D. 21:
Further questions? Senator King.

Senator John A. King, D. 18:
If it's not mandatory you don't even have to participate, why all the concern?

Tom Harte:
Why am I alarmed? Well I first say the bill last year, when it was in the House of Representative, I thought that it was an interesting concept. I also thought it was interesting because it would offer for multiple HCPC's. So that my company could actually start there own HCPC's and go to Tufts Health and Harvard and Blue Cross.

But then I looked into it further and I said "well right now we are in guarantee issue State" and we're community rated across the board. In the event that we were to pull from the million dollar pool of individuals, let's just say 30,000 people, how would that adversely effect the rates in a community rated pool?

Insurance works on being able to determine the risk. The greater the pool the better the insurance companies get to determine that risk. You pull those 30,000 people out then that would adversely effect their ability to calculate the risk across the board.

So that was my first concern, the other concerns that I have are related to "is it really cost effective for the State of New Hampshire to" and I am not an expert in policy I'm only an expert in consumers, I deal with them every single day. Is it cost effect for them to setup a new system a Health Insurance Purchasing Cooperative, duplicating what I do everyday and duplicating what the health care plans do everyday? Does that answer your question?

Senator John A. King, D. 18:
I gather from your testimony you look at the whole picture?

Tom Harte:
Yes.

Senator John A. King, D. 18:
Is it a better thing for the people; the small companies of New Hampshire or isn't a better thing? Everybody, companies can join this, insurance companies can join this. They all take that risk one way or another.

Tom Harte:
I don't think that the State of New Hampshire needs to set up the lengths that they are looking at for a Cooperative to be able to do that. I think that a simple solution such as a bill dealing with the 37 ½% requirement, to go back to allowing me to offer choice to my employees.

Senator Katherine W. Wheeler, D. 21:
Questions? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
I ask this question of the last speaker, would you agree with me, in your capacity as a consultant, that in all likely hood that if you had employer with, who wanted 50 life's insured versus an employer that wanted 5,000 life's insured that in all likely hood you'd be able to better price per life for that 5,000 block of business versus the 50 live block of business? Is that a fair statement?

Tom Harte:
I don't claim to be an expert in actuarial sciences but what I do know is that we have a lot of employer clients in New Hampshire and through out New England and New York, that are larger clients that may at times, and I don't the percentage but it's pretty well balanced, at a higher price per capita then our smaller employer clients. All of my smaller employers might be a younger group with an average age of 30-35 years of age. Where as an established employer, a larger employer, have an older practice. So, by having a 5,000-group pool doesn't necessarily help my small company.

Senator Leo W. Fraser, Jr., D. 4:
I guess maybe it's not a fair question. But if you had the same, you could offer the same product, it seems to me in my experience would you believe, that someone goes to market with an offer to insurance 5,000 life's in all likely hood there going to get a better price than someone goes to market trying to insure 50 life's, using the same product.

Tom Harte:
Exactly. If your questions is if I had a group of 5,000 with similar demographics as the 50-person group, then to answer that question, yes.

Senator Leo W. Fraser, Jr., D. 4:
Thank you very much.

Senator Katherine W. Wheeler, D. 21:
Any further questions? Seeing none, thank you very much. Our last two speakers would be Suzanne Amidon first, then Yvonne Nanasi. After that the Committee is going to carry out its hearings in Rep's Hall for the next bill. So there will be a change of venue after these two people testify. I am going to ask Senator Hollingworth to deal with this and I am going to go work on my eye.

Suzanne Amidon – General Counsel - NH Hospital Association:
Good Morning, Madam Chairman, my name is Suzanne Amidon, General Counsel for the New Hampshire Hospital Association.
(See attached written testimony, Document #9).

Senator Beverly A. Hollingworth, D. 23:
Questions from the Committee? See none, thank you very much. Yvonne Nanasi.

Yvonne Nanasi– Director of Government Relations– BCBSNH:
Thank you very much Madame Chair, Members of the Committee I will be very brief, as I understand you have chiropractor next.
(See attached written testimony, Document #10).

Senator Beverly A. Hollingworth, D. 23:
Thank you very much. That ends those who have submitted a card wishing to speak. We do have a card from Judith Ryan in support of the bill but not wishing to speak. Thank you all for coming, I will close the hearing on **SB162**.

Hearing closed on SB162 at 10:30am.

Respectively submitted,
Linda Brosseau, secretary

Sen. Fraser

SB 162

This bill establishes standards for a voluntary health insurance purchasing alliance. The alliance would be run by a nonprofit corporation and would be available to small employers statewide. The operation of the alliance would be overseen by the Insurance Department.

Small employers need help providing health insurance coverage for their employees. On an individual basis, small employers simply do not have the resources to effectively shop around and negotiate and contract with health carriers. By consolidating purchasing responsibilities and resources, small employers will gain much-needed bargaining clout and purchasing savvy. They will also be able to give their employees something they do not now have but greatly desire–namely, choice of health plans. An added benefit is that certain administrative costs, such as costs associated with contracting, enrollment, and premium collection and payment, will be reduced through economies of scale.

Over the summer, I participated in the SB 494 study committee on purchasing alliances. We heard from experts on the subject and collected a great deal of information on the operation of purchasing alliances in other states. What I have concluded is that, if properly structured, a health insurance purchasing alliance can provide significant benefits to small employers and their employees with no significant downside.

○

Document #1

The health carriers have mostly opposed and lobbied against this idea, and there is something very interesting about that. What is interesting is that, for at least the last five years, the health carriers have been trying ~~desperately~~ to grow or consolidate. The reason they have given for wanting so very much to do this is the importance of market strength and economies of scale. And, indeed, there has been a great deal of market consolidation on the supply side of the health insurance market.

Unfortunately for the purchaser, there has been very little consolidation on the demand side. Today, with this bill, I put forward the old notion that what's good for the goose is good for the gander.

Document #2

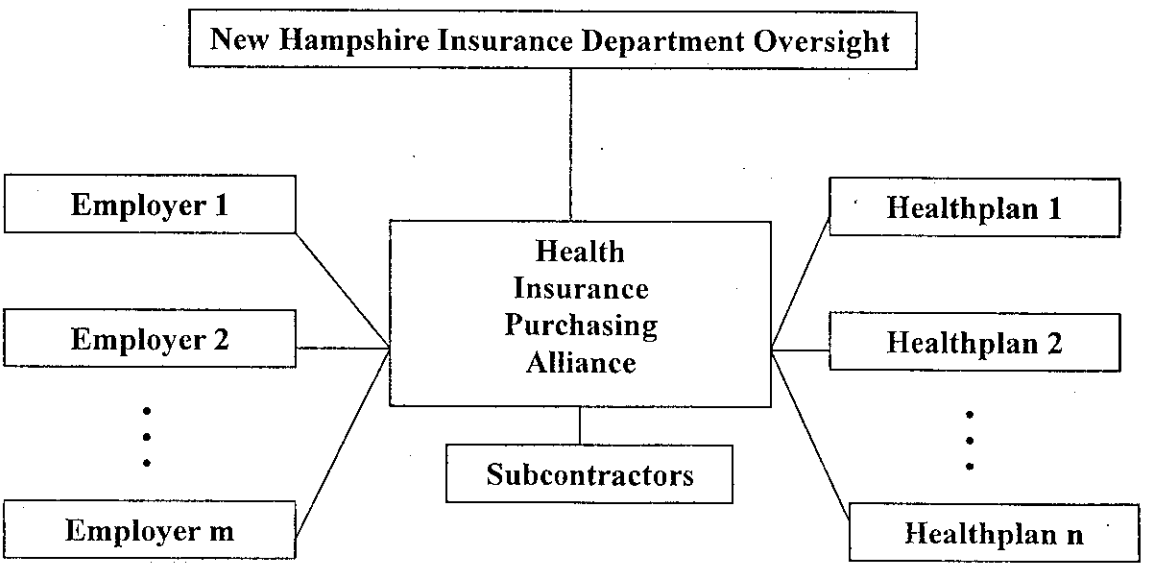
SB 162:

An act establishing the voluntary small employer purchasing alliance

What is a Health Insurance Purchasing Alliance (HIPA)?

A HIPA is a private organization through which businesses join forces to purchase health insurance for their workers. The primary goal of a HIPA is to obtain better value in purchasing health insurance by consolidating purchasing responsibilities and resources, thereby:

- increasing bargaining clout and purchasing expertise
- reducing the administrative cost of health plan contracting, enrollment, premium collection and payment for multiple employers, and
- giving consumers a meaningful choice of competing health plans.



What a HIPA does

- ✓ Negotiating and contracting
- ✓ Marketing
- ✓ Enrollment
- ✓ Premium collection and distribution
- ✓ Consumer information
- ✓ Data analysis and evaluation
- ✓ Plan performance measurement
- ✓ Quality improvement

What a HIPA doesn't do

- x Bear risk
- x Directly pay individual health care providers
- x Market for just one carrier
- x Provide health care services
- x Function as a health plan (HMO, PPO, etc)

A HIPA can help us achieve the following important health goals:

Reduce costs for health insurance by:

- aggregating purchasing power to negotiate with health plans
- reducing administration costs

Enhance employee choice of plans by:

- encouraging participation of multiple health plans
- allowing employees to choose among health plans available through the HIPA

Foster competition based on value by:

- ensuring consumers receive clear information about plans including plan quality
- requiring plans to offer standardized benefit packages for "apples to apples" comparisons
- reducing the opportunity for health plans to engage in risk selection and cost-shifting from other purchasers
- reducing the incentive for health plans to risk select by risk adjusting rates

Enhance quality by:

- providing consumers with information to compare plans for best value
- negotiating with plans to set specific quality improvement goals

Reduce the overall level of uninsurance by:

- making insurance more affordable
- discouraging risk selection

Why organize a HIPA for small employers?

Small employers have the most difficulty covering their employees. An alliance will facilitate the purchase of health insurance for small employers.

- Of the 54 million Americans between the ages of 18 and 65 who are employed in businesses with 100 or fewer workers, only 40% obtain health insurance from their employer compared with 83% of employees in firms employing 1,000 or more workers.

A HIPA will increase choice of plans available to its members

- Workers in small firms tend to have little choice of plans.
- In 1996, 80% of the small firms that offered coverage offered only one plan.
- Only 6% offered choice from 3 or more plans.

A HIPA can increase the efficiency of the health delivery system

- The cost of health insurance as measured by the difference between premiums and benefits paid (the "loading charge") is greater for small firms than for large firms. This is due to the fact that administrative costs involved in insuring a small employer can be high.

Document #2a

SB 162: Questions and Answers

1. Q: Why is a small employer purchasing alliance needed?

   A1: Small employers have an especially hard time providing insurance coverage for their employees. They are much less likely than large employers to provide any coverage at all to their employees or to provide employee choice of plans. In addition, employee's out-of-pocket costs tend to be higher for small employers. This bill would provide a mechanism for small employers to band together, thereby giving them the same purchasing advantages (e.g., economies of scale, increased purchasing power) that large employers now enjoy.

   A2: Also, the health plans themselves are busily banding together for improved market position. This in itself increases the need for small employers to improve their own market position.

2. Q: Why do we need this kind of alliance? Why aren't the existing trade associations and trusts enough?

   A1: The existing group purchasing mechanisms are not available to most small employers.

   A2: The many of the existing group purchasing mechanisms are not large enough to get the kind of bargaining clout we are looking for and at the same time to offer choice of plans.

3. Q: How is it going to help us to create another government bureaucracy?

   A: This is not a government bureaucracy. This bill simply sets groundrules whereby a private nonprofit corporation will administer the purchasing alliance. The oversight function is performed by the Insurance Department.

4. Q: Isn't the small group market functioning well right now in the sense that there has been a lot of competition? If it ain't broke, why should we fix it?

A1: In the last few years, there has indeed been a fair amount of price competition in the small group market. This is because the name of the game has been market share. Health plans have opted for reduced margins and even significant losses in exchange for a chance at improved market share. But this is changing and plans are beginning to implement large price increases as they seek to recover from the rigors of vying for market share. At the same time, the market continues to consolidate on the supply side with only three plans having the lion's share of the market.

A2: Even with the increased price competition in this market in the past few years, things have still been far from adequate for the small employer. Many small employers cannot offer coverage or choice of plans to their employees. This puts them at a competitive disadvantage relative to employers in other states and in the world economy. The New Hampshire small employer could truly benefit from the economies of scale and increased bargaining clout that a purchasing alliance would offer.

5. Q: Isn't it true that small employers already have choice of plans and that an alliance would not improve this?

A: Certainly small employers have a choice in the current market. They can choose to contract with any of a number of health plans. But that is not the choice that we are talking about. We are talking about the ability of small employers to offer choice of coverage to their employees. Because of the administrative difficulty of contracting with health plans and because of health plan conditions about participation rates, most small employers who do offer coverage offer only one plan. So the only choice that is given to the employee is of the "Take it or leave it" variety. We will not have true competition in the small group market until we have consumer and not just purchaser choice of plans.

Document #3

Testimony for SB 162 – an act to establish the voluntary small employer health insurance purchasing alliance

Good morning Madame Chairwoman and members of the Committee, my name is David Larrivee and I am the Director of Market Relations for Tufts Health Plan. On behalf of Tufts Health Plan I thank you and your committee for the opportunity to testify on Senate Bill 162.

Tufts Health Plan is opposed to SB 162 because it is duplicative and unnecessary and potentially threatening to the healthy, competitive small group market presently existing in New Hampshire. Therefore, we do not see the need for yet another layer of bureaucracy.

In 1994, the New Hampshire Legislature passed small group market reform and since that time, a competitive environment has formed among the small group carriers. Small group carriers have seen a steady growth in the market, the number of small group policies has increased by 89%, the number of covered lives has increased by 31%, the average group size has declined, and the number of carriers writing in the small group market has grown.[1]

Given the growing small group market in New Hampshire, Tufts Health Plan opposes to SB 162 for a number of reasons.

First, the introduction of a Purchasing Alliance will not reduce costs. Fees assessed in connection with the operation of the Alliance will negate any cost savings to the small group employer and/or the consumer. For example, the proposed model calls for all member employers to pay the costs incurred or anticipated by the Alliance in connection with the operation of the Alliance.

Health plans would also incur costs should the Alliance develop uniform standards for data to be collected and provided to it and its members. New Hampshire HMOs already answer to a broad range of organizations that measure health care quality. These organizations include federal and state government agencies and independent not-for-profit review groups. One of these review groups, the National Committee for Quality Assurance (NCQA) serves as the national accrediting body for HMOs. The standards set by NCQA are purposely set high to encourage health plans to continuously enhance their quality of care.

In order to assure high quality patient care, Tufts Health Plan already maintains internal quality assurance and utilization management systems. These systems afford our members a level of accountability and protection. Tufts Health Plan's quality assurance programs also allow us to evaluate health outcomes and collect data in order to identify areas of strength and target resources to those areas that need improvement.

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[1] Senate Bill 711 final report, An Investigation Into the Effects of the New Hampshire Health Insurance Reform Law, RSA 420-G, pp. 47-48 (1977).

Health plans also collect and report HEDIS data (Health Employer Data and Information Set). HEDIS data is a core set of performance measures used to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance. HEDIS measures are constantly being refined and updated to meet the changing needs of employers and other purchasers.

SB 162 also calls for any marketing, advertisement, or education materials for health coverage sold through the Alliance to be approved by the Alliance prior to its use. At the moment, health plans have marketing materials that are approved both by their legal counsels as well as the Department of Insurance. Alliance approval of these marketing materials just adds another layer of administration, not to mention more costs for the health plans participating in the Alliance who would be required to pay funds into marketing pools.

If a Purchasing Alliance were to develop, two risk pools would be created in the current small group market. From here, there is potential for negative impacts on the existing and successful risk pool established by the small group law. For example, the small employers who did not belong to this Alliance could end up paying a higher cost for health care because of the risk selection imbalance. Furthermore, by requiring a standard product, there will be no incentive on the part of health plans to be creative in what they can or cannot offer to a small employer. From the employee's perspective, what is the incentive to chose one plan over the other? How does this foster a competitive environment in the marketplace? How will the Alliance explain the differences between the health plans?

Tufts Health Plan also believes that SB 162 would be harmful to those individuals who are already struggling to afford health insurance for themselves and their families. If the purpose of the proposed legislation is to lower costs, thereby increasing access for some portion of the presently uninsured segment of the population (the working poor), the proposed legislation is the wrong method. For example, other states which have enacted purchasing alliance legislation in the early 1990's faced enormous problems of adverse selection. The standardized products offered through the health insurance purchasing cooperatives were more expensive than the more innovative and streamlined products that could be offered outside of the cooperatives. Employers with health employee populations forced to the non-cooperative products, leaving those with disabilities and chronic illnesses to flood the cooperatives pool.

Furthermore, the current Alliance also allows any late enrollees to enroll in any health benefit plan that is available through the Alliance. This would mean an employee can choose not to enroll during standard open enrollment, find out they have a condition or illness that requires medical treatment later in the year and enroll to have the claims paid.

Finally, without knowing what level of enrollment is anticipated, it is difficult to predict the viability of the Alliance. Experience in other states demonstrates that states such as New Hampshire, with small populations, are inappropriate forums for the purchasing

alliance model. For example, Maine passed a purchasing alliance statute in 1996 and no voluntary pools have been created since the passage of these laws.

For these reasons, Tufts Health Plan opposes SB 162. I thank you and your Committee for this opportunity to address this very important issue this morning. I would be happy to answer any questions the Committee may have at this time.

Document #4

April 12, 1999

The Honorable Katherine Wheeler
Chair, Senate Committee on Insurance
Legislative Office Building
Room 102
Concord, NH 03301

RE: Senate Bill 162

Dear Senator Wheeler:

I am writing to express Harvard Pilgrim Health Care of New England's opposition to Senate Bill 162 – An Act Establishing the Voluntary Small Employer Health Purchasing Alliance.

Purchasing alliances, often referred to as Health Insurance Purchasing Cooperatives (HIPCs), have been tried in other states. Experience shows that, in all but the largest states, carriers offering coverage through the alliances lose money and cannot maintain themselves in the marketplace. In the smaller states, coverage offered through the HIPCs has typically been more expensive than other coverage available in the marketplace. Harvard Pilgrim believes that the result in New Hampshire would be the same, particularly given the number of requirements which would be applicable to carriers offering coverage through the HIPC.

In addition to opposing purchasing alliances in general, Harvard Pilgrim has serious concerns about many of the specific components of the proposed alliance. These concerns include:

- The eligibility requirements for coverage offered through the HIPC would be different than those applicable to the small group market, resulting in adverse selection against the HIPC products.
- The alliance could limit participation in the alliance to three (and possibly fewer) carriers, resulting in less choice for consumers.
- The lack of detail regarding the proposed risk adjustment mechanism.

The small group health insurance market in New Hampshire is functioning well. Many carriers are offering a variety of health plans to small businesses at competitive rates. In large part, this is the result of previous reforms enacted by the Legislature. Harvard Pilgrim does not believe that further legislative intervention in this market is warranted at this time.

For all of the above reasons, Harvard Pilgrim urges you to oppose Senate Bill 162. Thank you for your consideration.

Sincerely,

Thomas Gough
Direction, New Hampshire Operations and Development

STATE OF NEW HAMPSHIRE
DEPARTMENT of RESOURCES and ECONOMIC DEVELOPMENT
OFFICE of the COMMISSIONER
172 Pembroke Road P.O. Box 1856 Concord, New Hampshire 03302-1856

GEORGE M. BALD
Commissioner

603-271-2411
FAX: 603-271-2629
e-mail: g_bald@dred.state.nh.us

April 12, 1999

Members of the Insurance Committee

I am in support of SB 162 establishing a voluntary small employer health insurance purchasing alliance. Small businesses truly need this legislation. They typically have the most difficulty in obtaining health coverage for their employees. It would also make it more affordable for small businesses.

We deal with many small businesses on a daily basis, and the current number one problem is attracting and hiring qualified employees. Having the opportunity to provide health insurance will allow them to compete for experienced employees.

This is a reasonable proposal to assist small business owners to be more competitive and have the opportunity to grow and create new employment. I urge the committee to support the bill.

Sincerely,

George M. Bald
Commissioner

Document #5

Document #6

North Country
Health Consortium
25 Mt. Eustis Road, Littleton, NH 03561

Ammonoosuc Community Health Services, Inc.
Littleton, NH 03561

Androscoggin Valley Home Care Services, Inc.
Berlin, NH 03570

Androscoggin Valley Hospital, Inc.
Berlin, NH 03570

Androscoggin Valley Mental Health & Developmental Services
Berlin, NH 03570

Coos County Family Health Services, Inc.
Berlin, NH 03570

Littleton Regional Hospital, Inc.
Littleton, NH 03561

North Country Home Health Agency, Inc.
Littleton, NH 03561

Tri-County Community Action Program, Inc
Berlin, NH 03570

Upper Connecticut Valley Hospital, Inc.
Colebrook, NH 03576

Upper Connecticut Valley Mental Health & Developmental Services

Weeks Hospital Association, Inc.
Lancaster, NH 03584

White Mountain Mental Health & Developmental Services
Littleton, NH 03561

SENATE BILL 162: Health Insurance Purchasing Alliance
Summary of Testimony to Senate Insurance Committee

1. We have a potentially serious situation developing in the health insurance market for Northern New Hampshire.

2. Many employers have been faced with severe health insurance premium rate increases in recent months. This situation has created a scramble to find new, affordable sources of coverage within a market that already has very limited choice.

3. The proposed small business purchasing alliance offers an important vehicle for addressing this problem, particularly for Northern New Hampshire.

4. Northern New Hampshire communities are characterized by inter-related circumstances of lower median household income, greater self- and small-business employment, and higher rates of uninsurance or under-insurance relative to the rest of New Hampshire.

5. High rates of uninsurance and underinsurance are undoubtedly correlated with the higher rates of small business and self-employment. Among small employers (under 50 employees), 51 to 58 percent of businesses offer health insurance to their workers in contrast to large employers, of which 91 to 96 percent are estimated to offer insurance.

6. The difficulties faced by small employers in purchasing insurance are also factors that inhibit small purchasers' ability to use their purchasing dollars to improve quality or to participate meaningfully in the marketplace.

7. A group purchasing alliance could yield significant community benefit by:

   A) facilitating broader and more informed consumer choice;
   B) expanding access by making available more affordable health insurance options; and
   C) encouraging greater community involvement in health care issues by disseminating information on quality, cost, and outcomes to support value-based decision-making.

8. Such a plan could have widespread impact in Northern New Hampshire where small businesses are prevalent, plan choice is currently limited, and rates of uninsurance and underinsurance are high.

North Country
Health Consortium

25 Mt. Eustis Road, Littleton, NH 03561

Ammonoosuc Community
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Androscoggin Valley Hospital,
Inc.
Berlin, NH 03570

Androscoggin Valley Mental
Health & Developmental Services
Berlin, NH 03570

Coos County Family
Health Services, Inc.
Berlin, NH 03570

Littleton Regional Hospital, Inc.
Littleton, NH 03561

North Country Home
Health Agency, Inc.
Littleton, NH 03561

Tri-County Community Action
Program, Inc
Berlin, NH 03570

Upper Connecticut Valley
Hospital, Inc.
Colebrook, NH 03576

Upper Connecticut Valley Mental
Health & Developmental
Services

Weeks Hospital Association, Inc.
Lancaster, NH 03584

White Mountain Mental Health
& Developmental Services
Littleton, NH 03561

TESTIMONY TO SENATE INSURANCE COMMITTEE

Good Morning. My name is Jonathan Stewart. I am the General Manager of the North Country Health Consortium - an organization formed by ten health and human service organizations serving Northern New Hampshire. The organizational members, which are listed on this handout, include four community hospital systems, two home care organizatio two community health centers, a mental health and developmental service agency, and a community action program. I am here today because I believe we have a potentially serious situation developing in the health insurance market for Northern New Hampshire. I am also here because I believe the proposed small business purchasing alliance offers an important vehicle for addressing this problem.

As you are aware, many employers have been faced with severe health insurance premium rate increases in recent months. Among our own consortium members, premium hikes are ranging from 30% to 49% for their employee health benefits. As health providers, we also encounter many examples of employers and employees facing similar difficulties fo maintaining adequate health coverage. This situation has created a scramble to find new, affordable sources of coverage within a market that already has very limited choice. The affect of the rate adjustment and limited choice in the health insurance market is a particula hardship for the many individuals and families employed in small businesses or who are self employed.

Northern New Hampshire Concerns

Northern New Hampshire communities are characterized by inter-related circumstances of lower median household income, greater self- and small-business employment, and higher rates of uninsurance or under-insurance relative to the rest of New Hampshire.

- Residents of Northern New Hampshire towns are nearly 4 times more likely than residents of other New Hampshire towns to live in a federally-designated underserved area due to limited access to care and poor economic conditions.

- Compared to the rest of New Hampshire, the northern region exhibits significantly higher incidence rates (i.e. >10% higher) for important preventable indicators such a mortality due to external causes (e.g. motor vehicle accidents, other accidents, suicide), maternal smoking, cancer of the lung, breast and colon, chronic obstructive pulmonary disease, and ambulatory care sensitive hospital admissions *(NewHampshire Primary Care Access Plan data; 1997).*

- The risk of being uninsured for an individual in Northern New Hampshire is 20% higher than for an individual in the rest of New Hampshire *(Behavioral Risk Factor Survey data; 1991-1995)*. People who are employed, particularly self-employed individuals or workers in low-wage industries, and their dependents may represent as much as 70% of the uninsured population.

- In 1997, 51% of employed individuals in Northern New Hampshire were employed in firms with fewer than 50 employees compared to 41% of employed individuals statewide. *(New Hampshire Employment Security data; 1997)*

The Small Business Challenge

The high rates of uninsurance and underinsurance are undoubtedly correlated with the higher rates of small business and self-employment.

- Across the nation, 62.5% of metropolitan county residents are insured through employment-related sources compared with 53.7% of non-metropolitan county residents *(Medical Expenditure Panel Survey; Agency for Health Care Policy & Research; 1997)*.

- The likelihood that health coverage is purchased by a group purchaser is directly related to the size of the group to be insured. In surveys of small employers (fewer than 50 workers), 51 to 58 percent of businesses offer health insurance to their workers in contrast to large employers, of which 91 to 96 percent were estimated to offer insurance *(Cantor, Joel C., Stephen H. Long, and M. Susan Marquis, "Private Employment-Based Insurance in Ten States," Health Affairs 14(2):199-211; 1995)*.

- Among those employers that offer health insurance, most small purchasers choose to offer only one plan to minimize administrative costs and to maximize group size and purchasing power. The extent of employee choice often depends upon employer size; 32 percent of employers nationwide are estimated to offer only one health plan to their employees, but this varies from about 89 percent of very small firms (1 to 24 employees) to about 9 percent of very large firms (5,000 or more employees) *(President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry; 1997)*.

The difficulties faced by small employers in purchasing insurance are also factors that inhibit small purchasers' ability to use their purchasing dollars to improve quality or to participate meaningfully in the marketplace. Employers and employees in small firms often lack both the purchasing power and administrative capacity to obtain comparative information about health care quality or to apply available quality information in a meaningful way.

I might also say that this limited administrative capacity may be reflected in limited capacity to organize around legislation. One of the criticisms of the group purchasing alliance legislation I have been hearing is that there has not been widespread organization of small business to support it. I can tell you that every small business owner or representative of the small business community to whom I have talked about a group purchasing alliance has endorsed the concept. Perhaps the limited organized support of this legislation is indicative of the larger problem of limited time and capacity of small business owners to address health insurance issues; a situation that a group purchasing alliance would go a long way toward addressing.

The Health Purchasing Alliance Response

Considerable evidence now exists from a number of other States that health purchasing alliances can help to alleviate the problems of purchasing power and administrative capacity. The basic premise of a group purchasing cooperative is that by joining together, small groups can reduce their administrative costs, provide their employees with more choice, and have the ability to undertake value-based purchasing activities that are more readily available to larger group purchasers. At a minimum, such cooperatives can be the vehicle for effective consumer education on health care cost, quality and outcome issues thereby facilitating more informed participation in the healthcare marketplace. In many cases, such cooperatives have significant impact on the range of choice and affordability of insurance plans for health care consumers.

Such a plan could have widespread impact in Northern New Hampshire where small businesses are prevalent, plan choice is currently limited, and rates of uninsurance and underinsurance are high. It is our belief that the proposed purchasing alliance could yield significant community benefit by:

1) facilitating broader and more informed consumer choice;
2) expanding access by making available more affordable health insurance options; and
3) encouraging greater community involvement in health care issues by disseminating information on quality, cost, and outcomes to support value-based decision-making.

Considering the potential effect of the current insurance market environment on a historically fragile base of employer-sponsored insurance coverage, NCHC members believe that now is the time for action to avert a worsening health insurance situation in Northern New Hampshire.

Document #7

Lori Real, Director of Planning and Research
Department of Health and Human Services
Testimony on Senate Bill 162
Before the Senate Insurance Committee
April 12, 1999

Good morning, Madame Chairman and Members of the Committee. For the record, my name is Lori Real. I am director of the Office of Planning and Research, with the Department of Health and Human Services.

I am here today to express the Department's support for Senate Bill 162, which would allow small employers to come together to purchase health coverage from health plans.

We believe that the purchasing alliance can enhance employees' choice of health plans, give them better information on quality and performance, and help discipline market prices.

The Department recently conducted a broad public discussion about health care with a large number of citizens across New Hampshire. This work is described in the Department's October 1998 report titled *The New Hampshire Health Care System: Guidelines for Change.* This public input identified major concerns about the current health care system. Here are four leading concerns discussed in the report:

- concern about the affordability of health insurance
- concern about limited choice -- most employees can choose from only one plan
- concern about the lack of information to enable comparisons among health plans and make informed choice
- concern about the need to promote quality monitoring and improvement.

The experience of health insurance purchasing alliances in other states suggests that this can be a viable mechanism for addressing these concerns. The alliances can

- bring more employees under the health insurance system
- offer employees better value and lower premiums
- give employees more choice of health plans, and collect and disseminate comparative plan information
- collect information on the quality of health plans and negotiate based on quality.

Research on other states' models has shown that four characteristics are particularly important to the design of an effective purchasing alliance:

1) Insurance market rules inside the purchasing alliance must be consistent with insurance market rules that exist outside the alliance -- for example, to try to increase access or decrease premiums for high-cost or high-risk individuals could lead to adverse selection and turn the alliance into a repository for such individuals.

2) To maintain an effective bidding process, there needs to be a strong level of commitment to the goals of the purchasing alliance and the market rules that support it. Otherwise, people will be wary of entering into it.

3) Standardized benefit packages are needed to make comparison shopping possible and to eliminate the option of selecting good risks into a particular plan by benefit design.

4) The role of insurance agents must be maintained since small employers are accustomed to working with them and they continue to serve a useful role in marketing and enrollment functions.

The model presented in this bill incorporates these characteristics, and for that reason we support it.

We are prepared to work with the Committee as this bill moves forward.

I would be happy to answer any questions.

Document #8

New Hampshire Association of Health Underwriters - NHAHU
Independent Insurance Agents of New Hampshire - IIANH

Written Testimony for Senate Bill 162
April 12, 1999

Let me begin by stating that New Hampshire Association of Health Underwriters (NHAHU) and the Independent Insurance Agents of New Hampshire (IIANH) strongly support meaningful health care reform. We recognize the need for fundamental reforms in the health insurance market which would guarantee the availability and portability of coverage and consumer choice. And we compliment the Department of Insurance for recognizing the value of the health insurance broker and their (DOI) pursuit of meaningful market reform.

While pooled employer or group purchasing arrangements might be initially viewed as a way to increase access to health coverage in the small employer market, we have significant reservations and concerns regarding the utility and effect on the marketplace of such arrangements. In addition, New Hampshire health plans, which have recently received high honors from national publications *(U.S. News and World Report, October 5, 1998; and Newsweek, September 28, 1998),* are required to provide guaranteed acceptance of eligible employers

One of the alleged benefits of purchasing alliances is their ability to reduce administrative and marketing costs by performing many of the administrative functions currently performed by small employers or carriers. Contrary to reducing these costs and making coverage more affordable for small businesses, establishing alliances will require the creation of costly new administrative structures and/or bureaucracies to manage and operate the buying groups, which could offset any economies of scale.

In our opinion, these new bureaucracies would inadequately perform important services already being performed by commercial insurers and their agents; such as consumer education, marketing, and claims administrative functions. There is little reason to expect that the buying group's administrators can accomplish these tasks more efficiently than the commercial insurers and agents.

Furthermore, while a pooled employer arrangement may be able to obtain somewhat lower premiums due to its collective buying power, any economies of scale would be reduced by the fact of administering the health plans of many small employers is not the same as administering the health plan of a single large employer.

Additionally, the health underwriters and independent agents strongly believe that a HIPC should be required to meet the same statutory and regulatory requirements. The current legislation promotes an **"un-level playing field".**

1. The current legislation exempts the alliance from the current 37 1/2% participation requirement, and
2. The alliance will receive a significant government subsidy not available to commercial insurers or their agents.

Let's not forget that the health care alliance does absolutely nothing to address the most significant problems existing today in New Hampshire:

1. The individual health care marketplace,
2. The increasing costs and utilization of health care services, and
3. The significant lack of hospital competition

Our associations believe the health insurance market requires reforms to address the major concerns of our consumers. We have supported legislation in the current legislative session to provide the following:

1. HMO grievance procedures (HB647)	SUPPORT
2. Set up a health insurance consumer advocate, DOI (HB602)	SUPPORT
3. Establish a healthcare quality commission (HB624)	SUPPORT
4. Modifications to the definition of small group (HB473)	SUPPORT

In our opinion, the best argument in support of a health insurance purchasing cooperative is giving the choice to the ultimate purchaser -- the employee. However, should the State of New Hampshire spend thousand of dollars on the development of a HIPC when the 37 1/2% participation rules from August of 1998 can be repealed. As a result, employers can offer multiple health plans without the concern of cancellation from their health plan provider.

We pledge to continue to work with the Department of Insurance, employer groups, and others to protect and improve the health insurance market of New Hampshire. Thank you for your time and consideration.

Thomas M. Harte is a Benefits Consultant with Landmark Benefits Group, Salem, New Hampshire. He can be reached at (603) 898-8833.

THE DEBATE OVER A HEALTH INSURANCE PURCHASING COOPERATIVE

Issues	Supporters	Opponents
Health Care Cost	Aggregate purchasing power to negotiate with health plans and reduced administrative costs would reduce premiums.	New Hampshire is a community rated state. As such, has "aggregated" purchasing power with health care plans already exists. A HIPA could adversely affect the community rates by removing a portion of the population from the existing system.
Employee Choice	HIPA would encourage participation of multiple health plans, allowing employees to choose among several plans.	Employers enjoy the flexibility today to offer multiple plans to its employees. Repeal of the 37 1/2% requirement would improve employee choice.
Competition	HIPA would foster competition by mandating standardized benefits, reduce the opportunity for health plans to engage in risk selection, and reduce incentive for health plans to risk select by risk adjusting rates.	In 1995 legislation was implemented to eliminate risk selection and risk adjusted rates. In addition, standardized benefits may stifle competition by eliminating unique product differences.
Quality	HIPA would enhance quality by providing consumers with information to compare plans for best value and negotiate with plans to set specific quality improvement goals.	New Hampshire enjoys participation of the best rated managed care plans in the United States (U.S. News and World Report, October 5, 1998).
Uninsured Population	HIPA would reduce the uninsured population making insurance more affordable and discouraging risk selection.	HIPA could increase the uninsured population by making insurance more expensive with its impact on community rates.

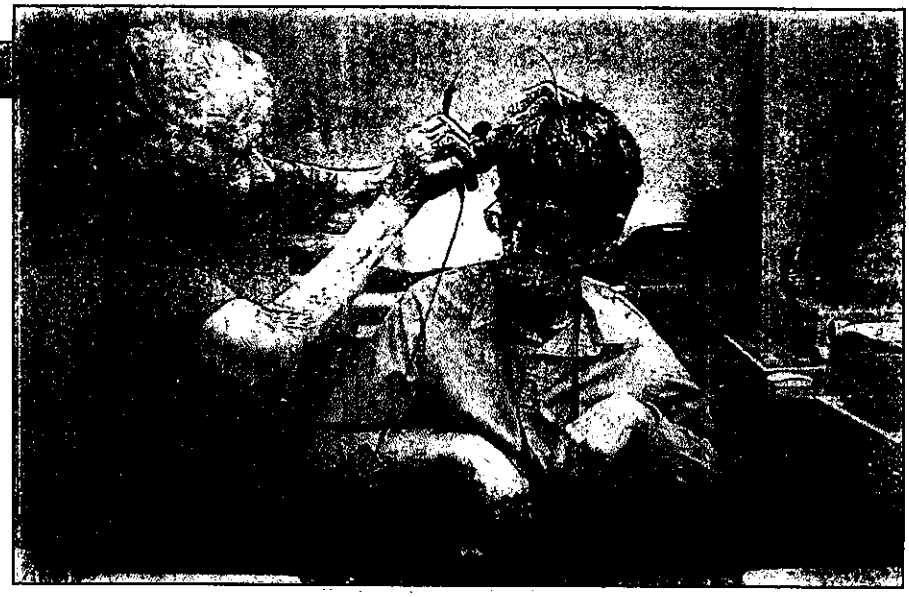
AMERICA'S TOP HMOs

PLAN	PLAN TYPE	U.S. NEWS RATING	SCORE	PREVENTION (AVG=61%)	ACCESS TO CARE (ADULTS) (AVG=86%)	MEMBER SATISFACTION (AVG=62%)	PHYSICIANS' CREDENTIALS (AVG=80%)	ACCESS TO CARE (CHILDREN) (AVG=82%)	ACCREDITATION STATUS
MICHIGAN CONTINUED FROM PREVIOUS PAGE									
Paramount Health Care	HMO	★★★	80	68%	94%	69%	88%	95%	Full
Medical Value Plan	HMO	★★★	80	66%	95%	71%	89%	93%	Full
Health Alliance Plan of Michigan	HMO	★★★	78	68%	91%	59%	85%	89%	Full
M-CARE	POS	★★★	75	73%	85%	NR%	85%	90%	1-year
Blue Care Network–East Michigan	HMO	★★★	74	66%	89%	60%	84%	88%	Full/Merger
SelectCare HMO	HMO	★★★	74	66%	91%	53%	90%	87%	Full
Care Choices HMO/Mercy Health Plans	HMO	★★★	68	61%	95%	63%	89%	65%	1-year
Physicians Health Plan of Mid Michigan	HMO	★★★	62	61%	95%	74%	NR	91%	None
Physicians Health Plan of Mid Michigan Plus	POS	★★★	60	62%	83%	75%	NR	89%	None
Blue Care Network–Southeast Michigan	HMO	★★★	60	56%	86%	57%	91%	79%	Full/Merger
Blue Care Network–Mid Michigan	HMO	★★	58	57%	81%	65%	73%	75%	Full/Merger
NorthMed	HMO	★★	54	63%	74%	NR	59%	78%	None
Physicians Health Plan of West Michigan	HMO	★★	46	52%	94%	70%	NR	73%	None
Physicians Health Plan of Southwest Michigan	HMO	★★	44	50%	92%	69%	NR	88%	None
Physicians Health Plan of West Michigan Plus	POS	★	40	51%	68%	68%	NR	68%	None
Physicians Health Plan of South Michigan	HMO	★	37	46%	89%	70%	NR	75%	None
Physicians Health Plan of Southwest Michigan	POS	★	30	43%	79%	61%	NR	81%	None
Physicians Health Plan of South Michigan Plus	POS	★	21	41%	49%	70%	NR	65%	None
Priority Health–Michigan	POS	★	0	NR	94%	NR	78%	91%	Full
MINNESOTA									
Medica Commercial	POS	★★★	69	68%	93%	NR	91%	90%	Full
HealthPartners	HMO	★★	56	55%	94%	61%	88%	NR	Full
Central Minnesota Group Health Plan	HMO	★★	46	49%	72%	63%	80%	85%	Full
MISSOURI									
Kaiser Foundation–Kansas City	HMO	★★★	72	65%	91%	56%	84%	85%	Full
Principal Health Care of Kansas City	HMO	★★★	65	59%	94%	58%	87%	90%	1-year
Group Health Plan–St. Louis	HMO	★★★	65	64%	83%	60%	67%	54%	1-year
Exclusive Healthcare–Kansas City	POS	★★★	64	65%	NA	NR	91%	83%	None
Group Health Plan–St. Louis	POS	★★	54	57%	80%	58%	67%	53%	1-year
Principal Health Care of Kansas City	POS	★★	50	56%	77%	NR	87%	87%	1-year
Exclusive Healthcare–Kansas City	HMO	★★	46	52%	89%	NR	91%	83%	None
Blue Cross Blue Shield of Kansas City	HMO	★★	45	51%	54%	59%	75%	86%	Full
Health Partners of the Midwest	HMO	★	40	44%	82%	66%	76%	83%	None
United HealthCare of Kansas City Choice/Select	HMO	★	28	37%	84%	66%	77%	NR	None
United HealthCare of Kansas City Choice/Select	POS	–	–	37%	70%	65%	NR	NR	None
NEBRASKA									
Exclusive Healthcare–Omaha	HMO	★★★	73	64%	94%	60%	85%	89%	1-year
Exclusive Healthcare–Omaha	POS	★★★	70	63%	93%	57%	85%	91%	1-year
United HealthCare of the Midlands Select	HMO	★★★	62	57%	93%	66%	74%	90%	Full
HMO Nebraska	HMO	★★	52	50%	93%	59%	89%	87%	Provisional
United HealthCare of the Midlands Select Plus	POS	★★	48	54%	60%	70%	49%	82%	None
HMO Nebraska	POS	★	38	44%	89%	55%	89%	82%	Provisional
NEW HAMPSHIRE									
Tufts Health Plan	HMO	★★★★	99	80%	96%	71%	83%	96%	Full
Harvard Pilgrim Health Care	HMO	★★★★	99	81%	96%	65%	83%	96%	Full
Matthew Thornton Health Plan	HMO	★★★★	90	76%	95%	70%	71%	95%	1-year
Healthsource New Hampshire–CIGNA	HMO	★★★★	87	73%	96%	64%	83%	94%	Full
United HealthCare of New England	HMO	★★★	73	69%	94%	74%	NR	87%	Full
BC/BS Blue Choice–New Hampshire	POS	★★★	73	69%	81%	64%	72%	NR	None
United HealthCare of New England	POS	★★★	69	68%	78%	71%	NR	87%	Full
Aetna U.S. Healthcare–New Hampshire	HMO	★★	51	57%	88%	NR	87%	67%	None
Aetna U.S. Healthcare–New Hampshire	POS	★★	45	54%	78%	NR	87%	60%	None

prepaid income also gives Master the flexibility to pay for whatever he thinks works best for the long-term health of each patient. An HMO, says Master, "is only as good as its care for its sickest patient."

Master's home visit to Gentile is typical of what makes the CMA model work. In Gentile's small living room, Master explains why he thinks the quadriplegic should enter a rehabilitation hospital. Master wants Gentile, at 270 pounds, to shed a recent 30-pound weight gain that now taxes his diminished chest-wall muscles. Gentile's odds of developing pneumonia this winter are high. And pneumonia, explains Master, could easily lead to other health problems that would rob Gentile of both health and independence. Master knows Gentile wants to vacation in Las Vegas and tells him he can still go if he enters rehab soon. Says Master: "We want to back you off the edge of the cliff you're sitting on."

Spend to save. Gentile's weight-loss treatment would last two to four weeks and cost up to $8,500. There's no certainty that it would work. A typical insurer, Master says later, would reject such expensive and speculative therapy, although it would pay for any hospitalizations that resulted later from a pneumonia. But in Boston, a day in the hospital runs about $1,500, and Master would rather gamble on a costly action now. "You've got to spend money to save money," he explains.



A device gave a voice to James Lessard, relieving his 84-year-old mother, Genevive.

Master feared Gentile would be reluctant to interrupt his life to move to a rehab hospital. But it takes only a little prodding before Gentile agrees. His nurse practitioner—a CMA employee who visits regularly—already has laid much of the groundwork. She has had long talks with Gentile about rehab. Most important, it turns out, she has won support for it from his girlfriend, too.

Nurse practitioners are key to the CMA model. These highly trained nurses can make diagnoses and order treatments. Mary Glover, like the other nurse practitioners, spends most of her day on the road, treating 40 quadriplegics at their homes and even, at times, at their work-

The Honor Roll

These managed-care plans earned a top four-star rating in this year's U.S. News *rankings of 271 plans. Scores (red) show performance on a scale of 0 to 100 in 28 measures of quality. The order reflects actual scores, which are rounded here. HMO means health maintenance organization. POS means point-of-service plan (note).*

The rankings begin on Page 81.

Note: HMOs cover all or most charges for care received within a network of providers; members pay for care received outside the network. POS plans are similar but pay much of the cost of out-of-network care.
Sources: National Committee for Quality Assurance (data); National Opinion Research Center (analysis)

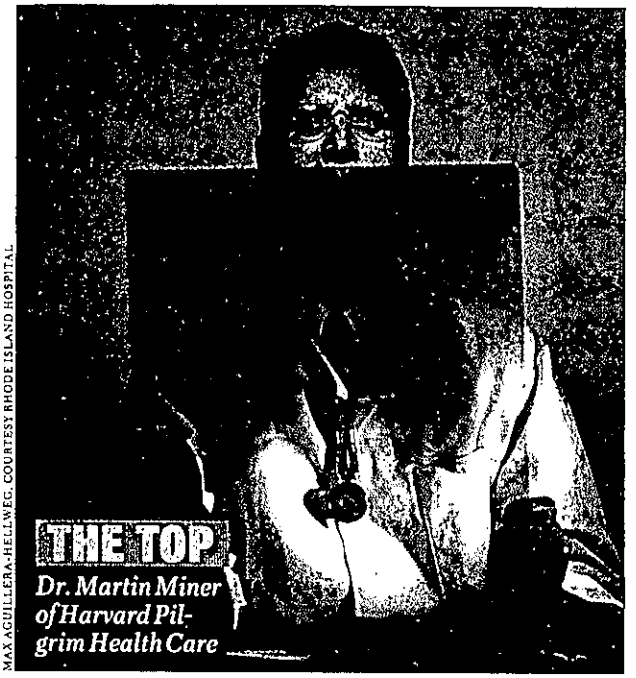
1.	Fallon Community Health Plan HMO (MASS.)	100
2.	Finger Lakes–Blue Choice HMO (N.Y.)	99
3.	Tufts Health Plan HMO (MASS., MAINE, N.H., R.I.)	99
4.	Harvard Pilgrim Health Care HMO (MASS., MAINE, N.H., R.I.)	99
5.	Welborn Health Plans HMO (IND.)	97
6.	Healthsource Massachusetts–CIGNA HMO (MASS.)	97
7.	BC/BS HMO Choice Maine POS	96
8.	ConnectiCare HMO (CONN.)	95
9.	Capital District Physicians' Health Plan HMO (N.Y.)	94
10.	Blue Cross and Blue Shield of Massachusetts–HMO Blue HMO	94
11.	Kaiser Foundation–Southern California HMO	94
12.	Preferred Care HMO (N.Y.)	93
13.	Group Health Cooperative of South Central Wisconsin HMO	93
14.	Health New England HMO (CONN., MASS.)	92
15.	Healthsource Maine–CIGNA HMO	91
16.	Matthew Thornton Health Plan HMO (MASS., MAINE, N.H., VT.)	90
17.	BC/BS HMO Maine HMO	90
18.	HealthAmerica of Pennsylvania–Pittsburgh HMO	90
19.	Blue Care Health Plan HMO (CONN.)	89
20.	Kaiser Foundation–Northeast HMO (CONN., MASS., N.Y., VT.)	89
21.	Finger Lakes–Blue Choice POS (N.Y.)	88
22.	Health Care Plan–New York HMO	87
23.	HMO–CNY HMO (N.Y.)	87
24.	Blue Care Health Plan POS (CONN.)	87
25.	Healthsource New Hampshire–CIGNA HMO (MASS., N.H.)	87
26.	Network Health Plan of Wisconsin HMO	86
27.	Keystone Health Plan Central HMO (PA.)	86
28.	Health Alliance Medical Plans HMO (ILL.)	85
29.	Independent Health–Western New York POS	84
30.	Keystone Health Plan West Blue HMO (PA.)	84
31.	Group Health Cooperative of Eau Claire HMO (WIS.)	84
32.	Physicians Plus Insurance HMO (WIS.)	83
33.	HealthPlus of Michigan HMO	83
34.	M–CARE HMO (MICH.)	83
35.	Independent Health–Western New York HMO	83
36.	HealthPartners Health Plans–Phoenix HMO (ARIZ.)	82
37.	Valley Health Plan HMO (WIS.)	82
38.	Priority Health–Michigan HMO	82
39.	Kaiser Foundation–Ohio HMO	82
40.	Kaiser Foundation–Northern California HMO	82

Ranking the Health Plans

NEWSWEEK'S annual survey gauges how well HMOs are serving their members

FOR NEWSWEEK'S THIRD annual ranking of managed-care plans, we surveyed more than 200 plans about practices that are known to improve families' health. Our rankings cover both classic health-maintenance organizations (whose members receive all their care from physicians within a network) and point-of-service plans (which cover some out-of-network services). We gauged performance in three areas—keeping members healthy, treating acute illness and managing chronic conditions—both for adults and for children. Working with the Foundation for Accountability, an Oregon-based nonprofit group, we monitored several measures of care within each of those categories.

We graded the plans on a curve. The one that performed best in a given category received a perfect 100 percent and the worst received a zero. So the letter grades in the columns below represent each plan's standing in relation to the others that provided information. The discrepancies were sometimes large. For example, the proportion of pregnant women who get prenatal care during their first trimester was as high as 99 percent in some plans, while in others it was only 38 percent.



MAX AGUILLERA-HELLWEG, COURTESY RHODE ISLAND HOSPITAL

THE TOP
Dr. Martin Miner of Harvard Pilgrim Health Care

The letter grades in the first column (Plan Ranking) represent each plan's overall performance. To calculate this general measure of excellence, we weighted kids' care at 30 percent and adult care at 70 percent, reflecting the plans' overall membership. In addition to quality grades, we've presented two other key measures for consumers: satisfaction and accreditation. To arrive at a satisfaction score, we subtracted the number of members who said they were highly dissatisfied from the number who said they were highly satisfied. Though this score was not factored into a plan's overall grade, it enables you to see how well different plans are doing at keeping their members happy. The accreditation column tells you whether a plan has passed muster with the National Committee for Quality Assurance in Washington.

As you scan the columns below, remember that a plan's overall grade is less important than its scores within each category. The needs of a 50-year-old with high blood pressure are very different from those of a 30-year-old with young children at home—and a plan that's perfect for one of those people may not work well for the other. When you're shopping for good health care, the difference is in the details.

	Overall			Adult care			Kids' care		
Rank/plan/state	PLAN RANKING	SATIS-FACTION	ACCRED-ITATION	STAYING HEALTHY	GETTING WELL	LIVING W/ILLNESS	STAYING HEALTHY	GETTING WELL	LIVING W/ILLNESS
1 Harvard Pilgrim Health Care, Mass.	A	B	yes	B	A	A	A	A	A
2 Tufts Health Plan, Mass.	A	A	yes	B	A	A	A	A	A
3 HMO Blue, Mass.	A	B	yes	A	A	A	A	B	B
4 Blue Choice, Rochester, N.Y.	A	B	yes	A	A	A	A	B	B
5 Group Health Cooperative of Puget Sound, Wash.	A	B	yes	A	B	A	B	B	B
6 United Healthcare of New England, R.I.-HMO	A	B	yes	B	A	A	A	A	B
7 Kaiser Foundation Health Plan of Hawaii	A	A	yes	B	B	A	B	B	B
8 Healthsource Massachusetts	A	B	yes	A	A	A	A	C	B
9 Anthem Blue Cross and Blue Shield of Connecticut	A	B	yes	B	B	A	A	B	B
10 United Health of Wisconsin Inc., POS	A	B	yes	A	B	A	B	B	B
11 Kaiser Foundation Health Plan of Ohio	A	B	yes	B	B	A	B	B	A
12 Kaiser Foundation Health Plan–Northern California	A	B	yes	B	B	A	B	B	A
13 Kaiser Foundation Health Plan of Colorado	A	B	yes	A	B	B	B	B	B
14 Matthew Thornton Health Plan, N.H.	A	A	yes	A	A	B	A	A	B
15 Kaiser Foundation Health Plan–Southern California	A	B	yes	B	B	B	A	B	A
16 Fallon Community Health Plan, Mass.	A	A	yes	B	A	A	A	B	B
17 Health Alliance Plan, Detroit, Mich.	A	B	yes	B	B	A	B	B	B

*HEALTH MAINTENANCE ORGANIZATIONS. †POINT-OF-SERVICE PLANS. THE FOUNDATION FOR ACCOUNTABILITY, A NONPROFIT DESIGNER OF HEALTH-CARE QUALITY MEASURES AND INFORMATION TOOLS, ADVISED NEWSWEEK ON SURVEY DESIGN AND ANALYSIS. OVERALL SCORES ARE WEIGHTED 30 PERCENT KIDS, 70 PERCENT ADULTS, TO REFLECT MEMBER POPULATION.

Document # 9

New Hampshire Hospital Association

Testimony in Support of HB 162,
Establishing Voluntary Small Employer Health Insurance Purchasing Alliance
April 12, 1999
Senate Insurance Committee

Good Morning, Madam Chairman. My name is Suzanne Amidon, General Counsel for the New Hampshire Hospital Association, which represents acute care and specialty care hospitals in New Hampshire. I am here to speak in support of HB 162.

The mission of the New Hampshire Hospital Association is "improve health" and one of our objectives is to increase access to health care by developing and supporting innovations to increase access. Our members have developed clinics which offer care on a free basis or on a sliding scale based on income, developed insurance programs for increased community based access, and even partnered with insurers to help offer small employers affordable health coverage.

The purpose of this legislation, to increase affordability of health care coverage by allowing small employer to work together to improve their bargaining power, furthers the objective of making insurance more accessible to working families in this state. We believe this is a complement to the Small Group Reform legislation initiated in this body and enacted into law 1995. It helps small employers to join in a purchasing alliance, on a voluntary basis, to increase their leverage in providing, designing and paying for health insurance for their employees and their families.

We know the Insurance Department may offer amendments to this proposal, however, we hope this Committee will vote "ought to pass" on some version of a small group purchasing alliance.

Thank you for your attention. I'll be happy to answer any questions you may have.

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Document #10

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Senate Insurance Committee
April 12, 1999

RE: SB 162 - Employer Health Care Purchasing Alliance
Submitted by: Yvonne Nanasi, BCBSNH Director of Government Relations

Blue Cross and Blue Shield of New Hampshire (BCBSNH) continues to support reforms in the individual and small group market that provide access and availability of health care insurance to the citizens of New Hampshire. BCBSNH agrees with the Governor and the sponsors of SB 162 that we must continue to explore health care system alternatives and actively seek out innovations. The next major health care market reform step that New Hampshire takes must be as widely discussed and as carefully scrutinized as were the 1994 reforms. Forming a statewide health care purchasing cooperative or alliance for small businesses is a major step. It is a step that can have far reaching impacts in the state's insurance market and health care services system.

Rather than base New Hampshire's next major health reform initiative on a theoretical model, the reform needs to be built upon gathering information from other similar state's and testing the New Hampshire small business market's demand for this new innovation. This is particularly important as recent studies have shown that New Hampshire's small group market is viable and, since the 1994 reforms, small employer insurance has expanded to include more family coverage.

As the state's largest insurer and in the best interest of our members - many of whom are small employers, BCBSNH would rather learn from other state's experiences rather than repeat their problems. We have spoken with several of our Blue Cross and Blue Shield plan colleagues in other states who have experience with the type of alliance being proposed in the bill. These conversations and the literature provided encouraged us to recommend that legislators consider the following while crafting this type of major step in New Hampshire's health care reform.

Our research, thus far, indicates that about 14 states have passed legislation to create or encourage the development of some form of employer health care purchasing cooperative or alliance. The success or failure of the concept varies from state to state for a variety of reasons. The major initial considerations we would ask legislators to consider before enacting SB 162 include:

* Start-up and operating costs for an employer's purchasing alliance are significant and crucial to its success. The majority of states that have fashioned lasting alliances found that the start-up funding for product design, marketing and administration was not only essential, but, more than anticipated and needed for a longer period of time than expected. For example, in 1993, North Carolina allocated $3.5 million to support alliance formation. In Florida, the legislature provided $275,000 per alliance (regional alliances) for the first year and $138,000 for the second year in addition to considerable administrative assistance from a state agency.

* Unsuccessful alliance efforts are available to learn from. Last year in Kentucky, legislation was proposed to "shut down" its purchasing alliance (supported by the Kentucky Insurance Department). When participating in the Kentucky Alliance, employers have to accept the standardized benefits that negotiated by the Alliance. In Kentucky the promised 1.5% administrative fee for alliance members was realized at about 4%. In addition to the small employers souring over the administrative fee increase, the university system and the state employees were not agreeable to the standardized plans as they could negotiate better deals with insurers. Furthermore, it seems that the third party administrator was not able to handle

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the alliance appropriately.
North Carolina and Ohio alliances have encountered difficulties in rural areas where the employers are interested but the insurers are not.

* Market segmentation and adverse selection are concerns. In smaller states that guarantee issue and community rate, like New Hampshire, there are the concerns among policy makers that voluntary quasi-governmental alliances will become magnets for high risk groups and fall into a death spiral of increasing costs and rates. Most alliance administrators strive to make their benefit plan offerings attractive enough to appeal to all small groups but much depends upon state's mandated benefit levels.
A small employer health care purchasing cooperative or alliance may segment the small group market to the disadvantage of those who are not participating, especially if the start-up or administrative costs are subsidized. Those employers who elect or are able to participate in the alliance may have healthier groups and be a better risk for insurers (See attached research funded by The Commonwealth Fund on the need for market adjustment mechanisms for alliances).

These and other considerations such as the composition of the alliance board of directors, ensuring a competent administrator, the reporting process, insurer participation requirements need to be discussed in order to craft an alliance mechanism for small employers that preserves the viability of the small group market, avoids the mistakes made by other states and moves our successful state reforms a step further.

Rather than create and fund a new bureaucracy, some states elected to enact very simple enabling legislation that allows for the formation of private nonprofit health purchasing alliances. This approach has been very successful in some states as the risk of operating the alliance remains among its' members - the employers. It would allow the state to test the potential interest and the ability of an alliance to function under current health care statutory requirements. Currently, NH law does not allow a different types of employer groups to form for the sole purpose of obtaining health insurance coverage. Changing this provision in our law may merit consideration.

In summary, BCBSNH supports the purpose and intent articulated in SB 162. Small Group Purchasing Cooperatives or Alliances have worked to the benefit of small employers in California and in some regions of other smaller states. Every opportunity that encourages small businesses to provide health insurance options to their employees should be sought out and carefully reviewed. BCBSNH is willing to tap into our nation-wide health care insurance resources in order to work with legislators on developing the next step in health insurance market reform that will work for New Hampshire's small businesses.

Directory of Consumer-Choice Health Purchasing Groups

compiled by the Institute for Health Policy Solutions

CALIFORNIA **Pacific Health Advantage (PacAdvantage)** *Date coverage available:* July 1993 *Size of employers:* 2-50 employee firms. Employers of any size if coverage is obtained through a qualifying trade association More Information	CONTACT INFORMATION *221 Main St.* *Suite 1500* *San Francisco, CA 94105* *949-766-1905*
COLORADO **The Colorado Health Care Purchasing Alliance** *Date coverage available:* November 15, 1995 *Size of employers:* Any size. More Information	CONTACT INFORMATION *501 South Cherry, Suite 900* *Denver, CO 80226* *303-333-6767* *303-322-3830/fax* *800-996-CHIP* *Info@alliance-colorado.org*
CONNECTICUT **CBIA Health Connections** *Date coverage available:* January 1, 1995 *Size of employers:* 3-50 More Information	CONTACT INFORMATION *350 Church St.* *Hartford, CT 06103-2022* *860-244-1900* *860-278-8562/Fax* *www.cbia.com*
FLORIDA **Florida Community Health Purchasing Alliance** *Date coverage available:* June 1, 1994 *Size of employers:* 1 to 50 employee firms More Information	CONTACT INFORMATION *PO Box 31214* *Tampa, FL 33631-3214* *813-286-2357 or 1-800-599-4816/fax* *1-800-4MYCHPA* *www.chpa.com*
ILLINOIS **IMA - Health Options** *Date coverage available:* October 1998 *Size of employers:* 2 to 50 employee firms More Information	CONTACT INFORMATION *Insurance Department* *IMA* *303 W. Madison, Suite 600* *Chicago, IL 60606* *800-482-0462*
MONTANA **Community Health Options** *Date coverage available:* January 1, 1998 *Size of employers:* 2 or more employees More Information	CONTACT INFORMATION *PO Box 4121* *Missoula, MT 59806* *406-721-6275* *No webpage, but questions can be emailed to Bill McDonald at:* *Wjmcdon@montana.com*
NEW YORK **Long Island Health Alliance** *Date coverage available:* February 1995 *Size of employers:* 3-50 employees More Information	CONTACT INFORMATION *Ellen Bass* *Director of Operations* *80 Hauppauge Rd.* *Commack, NY 11725-4495* *516-493-3008* *516-499-0167 FAX* *www.liassoc.com*
NEW YORK **New York Business Group on Health** *Date coverage available:* Mid- 1999 *Size of employers:* 2-50 employees More Information	CONTACT INFORMATION *New York Business Group on Health* *386 Park Ave. South* *Suite 508* *New York, NY 10016* *212-252-7440 x13*

NORTH CAROLINA **Caroliance** *Date coverage available:* November 15, 1995 *Size of employers:* Self-employed individuals and businesses with fewer than 50 employees More Information	CONTACT INFORMATION *State Health Plan Purchasing Alliance Board* *501 North Blount Street* *Raleigh, NC 27604* *800-873-6464* *www.caroliance.com* *ncshppa@mindspring.com*
OHIO **Council of Smaller Enterprises (COSE)** *Date coverage available:* 1974 *Size of employers:* 1 to 250 employees More Information	CONTACT INFORMATION *COSE* *200 Tower City Center* *50 Public Square* *Cleveland, OH 44113-2291* *216-621-3300* *888-304-GROW* *www.clevelandgrowth.com*
OREGON **Associated Oregon Industries** *Date coverage available:* August 1, 1997 *Size of employers:* 2-50 employees More Information	CONTACT INFORMATION *PO Box 12519* *Salem, OR 97309-0519* *503-588-0050* *503-588-0052/fax* *800-452-7862* *www.aoi.org* *Questions can be emailed to: kearls@aoi.org*
TEXAS **Texas Insurance Purchasing Alliance** *Date coverage available:* February 1, 1995 *Size of employers:* 2-50 employees More Information	CONTACT INFORMATION *1005 Congress Avenue* *Suite 550* *Austin, Texas 78765* *512-472-3956* *512-474-0167/fax* *800-839-8472*
UTAH **Care of Utah** This for profit consumer choice organization was formerly affiliated with the Utah employer coalition, Utah Health Cost Management Foundation.	CONTACT INFORMATION *801-355-2273*
WASHINGTON **HealthChoice** *Date coverage available:* July 1, 1996 *Size of employers:* 3 or more employees More Information	CONTACT INFORMATION *PO Box 658* *Olympia, WA 98507-0658* *206-943-1600* *206-943-5811/fax* *800-521-9325*

CHPGs on this chart have a Board of Directors with conflict of interest provisions and members who represent small employer consumers, offer a choice of multiple competing health plans, and have standardized benefits. All CHPGs meeting these requirements may not be included. Please contact the IHPS if you know of a small employer purchasing program that should be included.

IHPS HOME

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earthquake & flood also available
Countrywide

Group health purchasing pools listed by state

This list, compiled by the Institute for Health Policy Solutions, is not comprehensive. It focuses on groups that offer recipients a choice of health plans. If you don't see your state or region here, check with your local Chamber of Commerce or your state's insurance department to see if there is a group health insurance purchasing alliance.

State	Plan	Size of Firm	Region	Phone Number
California	Health Insurance Plan of California	2-50 employees	Statewide	(800) HIPC-YES
Colorado	Colorado Health Care Purchasing Alliance	Any size	Statewide	(800) 996-CHIP or (303) 333-6767
Connecticut	CBIA Health Connections	3-50 employees	Statewide	(860) 244-1900
Florida	Florida Community Health Purchasing Alliance	1-50 employees	Statewide (8 regional groups)	(800)-4MYCHPA or (813) 286-2357
Illinois	IMA - Health Options	2-50 employees	Chicago area	(800) 482-0462
Montana	Community Health Options	2 or more employees	None listed	(406) 721-6275
New York	Long Island Health Alliance	3-50 employees	Long Island plus Brooklyn, Queens, Nassau, and Suffolk Counties	(516) 493-3008
New York	New York Business Group on Health (not available until mid-1999)	2-50 employees	Five boroughs of New York City	(212) 788-8119
North Carolina	Caroliance	Fewer than 50 employees	Statewide	(800) 873-6464
Ohio	Council of Smaller Enterprises (COSE)	1-250 employees	Northeast Ohio	(888) 304-GROW or (216) 621-3300
Oregon	Associated Oregon Industries	2-50 employees	Statewide	(800) 452-7862 or (503) 588-0050
Texas	Texas Insurance Purchasing Alliance	2-50 employees	Statewide	(800) 839-8472 or (512) 472-3956
Utah	Care of Utah	None listed	None listed	(801) 355-2273
Washington	HealthChoice	3 or more employees	Statewide	(800) 521-9325 or (206) 943-1600

Source: Institute for Health Policy Solutions

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EMPLOYER PURCHASING COALITIONS AND MEDICAID: EXPERIENCES WITH RISK ADJUSTMENT

Melinda J. Beeuwkes Buntin and Joseph P. Newhouse, Harvard University
May 1998
Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to the Fund or its directors, officers, or staff.

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EXECUTIVE SUMMARY

Few problems in American health policy are more important—or more difficult to solve—than the problem of risk selection. Wherever buyers of health insurance are able to choose between two or more insurance options, some insurers may by chance enroll a group of members who are sicker or healthier than average. In addition, health plans have a clear financial incentive to induce healthier enrollees to select them and discourage sicker ones. Thus, the societal benefits of competition among health plans will never be fully achieved until incentives to select healthy enrollees are replaced by incentives to provide high-quality, cost-effective care.

Private employers, insurance purchasing coalitions, and Medicaid and Medicare managed care programs that offer a choice of health plans are all faced with the risk selection problem. In response, many analysts have called for the use of "risk adjusters" that would bring payments to health plans into line with the expected cost of caring for enrollees. This paper reviews a range of risk adjustment strategies currently in use in programs other than Medicare, including state Medicaid agencies, state employee health plans, state insurance pools and purchasing cooperatives, and business coalitions.

The experiences of these organizations offer several lessons. Their efforts confirm that implementing risk adjustment is very difficult, and that few entities are ahead of the Medicare program in using diagnosis-based risk adjustment. They prove that diagnostic risk adjustment systems can be implemented successfully, and that health plans seem willing and able to provide the data needed for diagnostic risk adjustment. They also show that less sophisticated systems, such as high-cost condition pools, are easier to implement than comprehensive risk adjustment systems but potentially less valuable. Another method, the "ceding" of high-cost cases back to fee-for-service coverage, has not been tried but should prove relatively easy to implement. Finally, it seems clear that the movement of sicker and disabled populations into Medicaid managed care programs increases the need for risk adjustment and that implementing risk adjustment methods for disabled Medicaid managed care enrollees is particularly urgent.

INTRODUCTION

Few problems in American health policy are more important—or more difficult to solve—than the problem of risk selection. Wherever buyers of health insurance are able to choose between two or more insurance options, some insurers may by chance enroll a group of members who are sicker or healthier than average. In addition, health plans have a clear financial incentive to induce healthier enrollees to select them and discourage sicker ones. Thus, the societal benefits of competition among health plans will never be fully achieved until incentives to select healthy enrollees are replaced by incentives to provide high-quality, cost-effective care.

Private employers, insurance purchasing coalitions, and Medicaid and Medicare managed care programs that offer a choice of health plans are all faced with the risk selection problem. In response, many analysts have called for the use of "risk adjusters" that would bring payments to health plans into line with the expected cost of caring for enrollees. This paper reviews the strategies to reduce risk selection being used in health insurance programs other than Medicare, following up on a previous paper (also produced with support from The Commonwealth Fund) that reviewed risk selection in the Medicare program and made a number of recommendations that were adopted in the Balanced Budget Act of 1997.

This review is not a comprehensive account of all the risk adjustment schemes currently in use. Even so, this sample shows decisively that, despite the theoretical benefits of risk adjustment, very few state Medicaid agencies or private employers have attempted to adjust payments to health plans to take account of risk. Rather, the conditions that foster risk selection seem to be increasing. In 1995, 62 percent of all workers offered insurance by their employers were given a choice among two or more health plans; the comparable percentage in 1991 was 46 percent. In firms with more that 200 employees, 84 percent of workers had such a choice in 1995, a growth of nine percentage points since 1993. This growth reveals a large and growing potential for risk selection among health plans.

THE PROBLEM OF RISK SELECTION

Purchasers of health insurance, both public and private, have found that attempts to contain costs by enrolling beneficiaries in managed care plans can be stymied by risk selection. Risk selection is especially likely to occur when beneficiaries are given a choice of remaining in a fee-for-service health insurance plan or enrolling in a managed care plan, since those who choose managed care tend to be healthier than average. If the managed care plan premium reflects the average rate for the entire group (or worse, if it reflects the average rate for those remaining in the indemnity plan), costs will rise. HMOs may attract so healthy a group of enrollees that even relatively low managed care premiums produce higher overall costs to the payor.

Medicaid managed care plans that feature voluntary enrollment are especially vulnerable to this problem. To apply for a federal waiver to

enroll Medicaid beneficiaries in managed care, a state must demonstrate that its capitation rate is below the average fee-for-service cost. As a result, state Medicaid agencies have historically set payments to health plans at 95 percent of the average cost of caring for a fee-for-service enrollee. Over time, favorable selection pushes up the average costs for beneficiaries remaining in the fee-for-service arrangement, thus raising HMO payments. In Medicare, where this cycle has also occurred, the Balanced Budget Act of 1997 broke the link between changes in the average cost of fee-for-service enrollees and changes in the capitated amount paid to health plans.

Like Medicare payments, Medicaid capitation payments are usually adjusted according to an enrollee's age, gender, and eligibility category, and place of residence is often weighed, as well. However, it appears that no comprehensive assessment of the predictive power of these adjusters within the Medicaid context has been conducted. Studies in the Medicare and private employer-sponsored contexts have not found these variables to be strongly predictive, and there is no reason to believe that the situation would differ markedly in Medicaid. Indeed, an investigation of the predictive power of these factors in the disabled Medicaid population found that age and sex predicted only 0.2 to 0.8 percent of the variation in disabled beneficiaries' annual costs, a percentage roughly similar to that predicted in Medicare by the adjusted average per capita cost (AAPCC).

As has also happened under Medicare, states may increase their overall Medicaid costs when they implement managed care programs. A RAND study of a Medicaid managed care demonstration found that a voluntary Medicaid HMO that appeared to reduce utilization had actually produced higher expenditures, after controlling for selection. Freund and colleagues, in an evaluation of six early Medicaid managed care demonstrations, found that "the rates established in several of the demonstration sites in the years examined were not accurate enough to yield the expected 5-to-10 percent savings." In fact, they found that costs in two sites were higher than they would have been in the absence of the demonstration.

Selection can potentially increase overall costs for private employers, as well. The Federal Employees Health Benefit Program, for example, has experienced problems with risk selection in its "high-option" indemnity insurance plan. Because government payments are tied partly to this plan but not to all plans, overall government costs may well have increased.

Most observers recognize that adjusting health plan premiums for risk can affect the terms of competition between health plans: plans may compete to deliver care efficiently to a given risk or they may compete by selecting individuals with lower-than-average service needs. Without competition over the efficient delivery of care, however, real savings for purchasers, including Medicaid and Medicare, are difficult to achieve. Because risk adjustment techniques attempt to bring health plan payments into line with the expected costs of caring for the individuals enrolled, competition to select good risks becomes less profitable.

The most intensive and promising research on risk adjusters has concentrated on diagnoses and prior use of health care services. The Health Care Financing Administration is funding two competing diagnosis-based risk

adjustment models for the Medicare population: the Ambulatory Care Group (ACG) system being developed by Jonathan Weiner and colleagues at Johns Hopkins University, and the Diagnostic Cost Group (DCG) system being developed by Arlene Ash and colleagues at Boston University. Another leading risk adjustment system for disabled Medicaid beneficiaries, the disability payment system, or DPS, is being developed by Richard Kronick and colleagues at the University of California, San Diego. As summarized in our earlier study, these methods still leave substantial room for risk selection, but they improve sufficiently on traditional methods to be worthy of implementation on a large scale.

RISK ADJUSTMENT BY STATES AND EMPLOYERS

Medicaid programs, states, and business coalitions have developed a variety of risk adjustment strategies, despite the absence of intensive, well-funded research on risk adjusters for their own populations. Their strategies include adapting the risk adjusters developed for the Medicare population, using the DPS, developing simpler risk adjustment methods focused on high-cost conditions, and negotiating premiums with health plans based on estimates of population risk.

State Medicaid Agencies

State Medicaid agencies appear to be in a particularly good position to implement risk adjustment. As they enroll new populations in managed care plans, for example, these agencies have access to comprehensive fee-for-service claims data that could be used for diagnostic adjustment. They also set standards for participation by health plans—a power that could be used to require participating plans to submit diagnostic data. According to Kronick and Dreyfus, however, Medicaid programs have done "more planning than implementation of health-based payment." Indiana, Wisconsin, and Ohio have used prior expenditures to adjust payments for a small number of patients in voluntary enrollment programs, and Minnesota and Oregon are now holding public hearings on risk adjustment.

Two states—Maryland and Colorado—have implemented more ambitious programs of risk adjustment. Maryland's Medicaid managed care program is using diagnostic adjustment. Colorado's system for the disabled Medicaid population is under consideration in other states. A more detailed look at developments in these two most advanced states may provide useful lessons.

Maryland. As part of Maryland's new Section 1115 Medicaid Managed Care program, participating HMOs are paid diagnosis-based capitation rates for many of their enrollees, using a risk adjustment methodology based on the ACG system. The program began enrolling beneficiaries in July 1997.

Under the ACG risk adjustment system, beneficiaries are assigned to groups based on diagnoses in their claims history. The cost of caring for beneficiaries in each group is then assessed and used as a basis for payment or cost estimation. In Maryland, groups with similar costs have been further combined into "resource adjusted categories." The costs associated with each group and category were calculated based on adjusted fiscal year 1995 claims of beneficiaries who were eligible for Medicaid for six months or more and were not enrolled in a managed care plan. In all, there are 17 "resource adjusted categories," 9 for beneficiaries in the

low-income women and children Medicaid population, and 8 for disabled beneficiaries. Separate rates were developed for neonates, persons with AIDS, and mothers eligible under Medicaid eligibility expansions. A supplemental payment is also made upon the birth of a child.

Maryland also developed adjusters for age, gender, and place of residence. These determine payments for beneficiaries without six months of Medicaid claims history, including newly eligible beneficiaries, beneficiaries who were enrolled in HMOs, and neonates. Interestingly, although the place of residence adjustment was made to reflect substantial differences in costs between those living inside Baltimore City and those living in other areas of the state, the discrepancies were found to be inconsequential after the ACG adjustments were made.

Colorado. Colorado has had a sizable voluntary enrollment into full-risk managed care plans by Aid to Families with Dependent Children recipients and people with disabilities. Approximately 20 percent of disabled beneficiaries are enrolled in such plans, and two plans enroll a total of approximately 85 percent of those individuals.

The impetus for risk adjustment grew out of a perception by managers of both of these plans that their organizations were experiencing adverse selection. One plan, Colorado Access, enrolled a particularly high-cost population through its university hospital and children's hospital, producing average expenditures twice those of the population as a whole before they enrolled in the plan. This led to an interim risk adjustment system based on prior expenditures of beneficiaries who switched into managed care plans: payments for disabled beneficiaries in 1997 were based on enrolled beneficiaries' 1995 fee-for-service expenditures.

Colorado has now implemented the DPS to adjust managed care rates for disabled beneficiaries. This system predicts costs more accurately for this group than the ACG or DCG system. To implement the DPS, Medicaid staff collaborated with state health plans and helped collect the encounter data needed for diagnostic risk adjustment. The plans submitted sufficient 1996 encounter data to enable the computation of adjusted payment rates for 1998.

State Employee Health Plans

State agencies other than Medicaid programs have also pursued strategies to limit risk selection and adjust health plan payments. The administrators of state employee health benefits plans are well aware of the danger that risk selection will increase their costs. Even so—and despite the fact that most states collect cost and utilization data—relatively few public employee benefits plans employ sophisticated risk adjustment methods.

Twelve states, or one of four, claim to adjust premiums within their public employee health benefits programs to reflect risk selection. In most cases, the adjusters are limited to the age and gender of enrollees: Virginia, for example, uses a prospective age/gender adjustment and calculates an end-of-year adjustment for plans with actuarially higher or lower risks. California and Washington use somewhat more sophisticated adjusters.

California Public Employees Retirement System (CalPERS). One of the largest

public employee benefits administrators, CalPERS uses demographic risk assessment in its rate-setting process. Rate targets are used to negotiate premiums with health plans. These targets are not "hard and fast" and are not released to plans before they submit bids. The extent to which premiums reflect the assessments, therefore, is not clear. Also, neither employee nor employer contributions are adjusted to account for risk differences. CalPERS and other employers who use similar methods do believe, however, that risk assessments improve their ability to negotiate successfully with health plans.

Washington State Health Care Authority. Washington's benefits program for public employees has used a risk adjustment system that incorporates demographic information and is now in the process of phasing in a diagnostic-based system. Early in the development of the new system, researchers at the University of Washington, led by Carolyn Madden, used data from six health plans to test three risk adjustment models: Diagnostic Cost Groups, Ambulatory Care Groups, and chronic disease scores. The research team now is implementing a prospective payment system based on a variant of the DCG model. Plans began to be paid under the new system in January 1998.

Before implementing the new system, the authority identified 23 areas in which detailed analysis would be needed, including the use of inpatient and/or ambulatory data, confidentiality and data security, nonstandard plan design, gaming, audits, cost of implementation, geographic variation, and outlier hospital payments. The use of ambulatory data, in particular, caused concern because of the difficulty and unreliability of data collection. As a result, the authority decided to adjust payments in 1998 by only plus or minus 2 percent, based on differences in risk measured by the DCG system. In the year 2000, plan payments will be fully adjusted using the DCG model and demographic adjustment will be phased out.

State Insurance Pools and Purchasing Cooperatives

In the early 1990s, a number of states created agencies to facilitate the purchase of insurance by small employers. Many of these efforts were subsequently repealed, but insurance pools continue to function in New York, California, and Washington.

New York. New York implemented open enrollment and community rating in its small group and individual health insurance market in 1993. To protect HMOs and other health insurers from experiencing losses due to adverse selection in these markets, the state also established an insurance pool.

To fund the pool, all insurers within a geographic region make quarterly per-beneficiary payments; the pool is then distributed according to demographic information—including age, gender, and family size of employees—and the presence of high-cost medical conditions. According to Sandra Hunt, a Coopers and Lybrand analyst working with plans to revise the risk adjustment methodology, the demographic adjustments triggered some adjustments across plans. These adjusters are being phased out over the next four years in favor of an expanded high-cost condition pool, which would transfer an equivalent volume of payments. The high-cost condition pool currently makes payments of approximately $7 million per quarter to insurers covering AIDS, transplant, ventilator-dependent, and neonate

patients.

Health Insurance Plan of California. Legislation in 1993 created the Health Insurance Plan of California (HIPC) to help small groups achieve the health insurance purchasing benefits of large employers. The legislation allowed the use of a prospective risk adjustment process in order to compensate participating carriers fairly.

The California Managed Risk Medical Insurance Board (MRMIB), which oversees the HIPC, has implemented a system that calculates the relative risk assumed by each health plan according to the age, gender, family size, and "marker diagnoses" of its enrollees. Marker diagnoses are high cost ($15,000 or more per year), relatively predictable diagnoses that are associated with inpatient stays. Participating carriers submit proof of marker diagnoses using claims or encounter data or case management or utilization review records. The marker diagnosis feature is easier to implement than a comprehensive diagnostic risk adjustment system, and the data are less difficult to obtain. By agreement of the MRMIB, adjustment is triggered only when a carrier's risk is 5 percent greater than the average assessed risk of all participating carriers.

In the first round of risk assessment and adjustment, conducted in 1996, approximately 1 percent of total premium dollars were reallocated among plans. The plan that received the most favorable selection paid $11.80 per contract per month (PCPM) into the pool, and the plan that received the most adverse selection received $46.04 PCPM. In 1997, less money changed hands overall, but more plans paid or received adjustments. Of 27 participating health plans, four paid out a maximum of $8 PCPM, and one (a preferred provider organization) received $16 PCPM. The lower volume of transfers reflects both changes in premiums and the departure from the pool in early 1997 of the largest receiver plan.

Business Coalitions

Business coalitions would seem to be in an excellent position to pursue innovative health purchasing strategies, including risk adjustment: they are not governed by federal or state regulations, are not tied to the political process, often have fairly substantial financial resources, and wield considerable market power. Also, because they typically offer employees of member businesses a choice of health plans, they would stand to gain from reducing risk selection.

For a variety of reasons, however, business coalitions are rarely leaders in risk adjustment. Still relatively new, coalitions must prove themselves accountable to member businesses looking for tangible health care savings and improvements in quality. They must avoid creating "winners" and "losers" among their members, who participate on a voluntary basis. Firms with lower than average costs may be unwilling to participate in a system that involves negotiating a single rate across firms. Also, business coalition administrators often lack the authority and resources to implement change. Finally, some employers may see risk adjustment as endangering labor relations. In the employment setting, implementing a risk adjustment scheme can be costly because younger, better-risk employees tend to be paid less and are more likely to have chosen low-cost plans. For those workers, premiums will tend to rise when a risk adjustment system is

implemented unless the employer compensates by raising the contribution rate.

Ninety-six local members participate in the National Business Coalition Forum on Health, but only 45 of those are involved in health insurance purchasing, which does not necessarily include contracting directly with health plans. Some use risk assessment primarily as a tool to negotiate premiums, often by employing projections developed by a private firm (such as MEDSTAT) for a demographically similar population in a similar community. Similarly, research by the General Accounting Office (GAO) has found that large employers use relatively crude risk adjustment techniques—often only age and gender—to evaluate premiums as a prelude to negotiations. Business coalitions that are currently investing in risk assessment and associated technologies employ a range of techniques, some more sophisticated than others.

Gateway Purchasing Alliance. This alliance, based in St. Louis, encompasses a range of employers with very different risk profiles, from small retailers to the United Auto Workers, a very high user of services. Although Gateway has succeeded in implementing only rudimentary adjustment strategies, these represent a significant improvement for employers, some of whom formerly paid premiums unrelated to their demographic profiles.

As a first step, Gateway provides managed care plans with demographic information on the alliance's entire covered population. Each plan then quotes a price for an average enrollee and a standard benefit design. The premium is adjusted to reflect changes in the benefit design (there are currently 70 variations) and the age and family size composition of each employer's prior-year managed care enrollees. To determine an employer's premium, demographic characteristics of that employee group are compared with those of the entire pool.

Pacific Business Group on Health (PBGH). This nonprofit coalition of 33 public and private employers in California and Arizona is among the most sophisticated now operating. With support from a foundation, PBGH collaborated with researchers from Kaiser Permanente and the University of California, San Francisco, to develop and test several risk adjustment models: a demographic model; a model including demographics and personnel variables, such as length of employment; a model including demographics and self-assessed health status; and each of those models with high-cost cases excluded. Excluding high-cost cases was found to be the most promising strategy, but personnel information also showed promise.

PBGH chose not to implement any of the models tested for several reasons. Their research showed, for example, that models built with data from one employer or health plan did not accurately predict risk for other employers or plans, while the personnel data proved difficult to work with and the group's survey of health status had a low response rate. Administrative difficulties, such as inconsistencies in employers' use of family size and other variables, were another stumbling block in creating categories to price. Also, although the study tested models only on enrollees under age 65, PBGH believes that its risk selection problem is especially acute in its retiree population, whose members typically have a choice between Medigap supplemental coverage and Medicare at-risk plan coverage. Finally,

PBGH employers did not reach consensus regarding thresholds for triggering a risk adjustment process or acceptable variations in risk mix across plans. At the same time, PBGH's participating health plans were most interested in geographic-based adjustments, although the analysis did not reveal consistent geographic variations in cost.

PBGH also found that price variation narrowed after it began using risk data to negotiate premiums and that "overall, risk spreads when PBGH employers were pooled did not vary much across plans." Even so, PBGH continues to pursue possible demographic and geographic risk adjustment strategies and is currently examining findings that indicate that marital status and the age and sex of an employee's dependents are reasonable predictors of costs. The alliance currently has no plans to use diagnosis information for risk adjustment.

Buyer's Health Care Action Group (BHCAG). Located in the Minneapolis/ St. Paul area, this alliance consists of 28 self-insured employers, with approximately 250,000 covered lives. Since 1993, BHCAG has offered its members a self-insured point-of-service plan called Choice Plus, which includes a negotiated fee schedule with a network of providers, a standardized benefits package, and administration by Health Partners and Aetna. Member employers have the option of offering Choice Plus alone or offering multiple plans.

Choice Plus succeeded in reducing costs by 11 percent in 1993, and its premiums have increased by only about 4 percent annually since then. Approximately 100,000 employees chose to enroll in Choice Plus, and membership in BHCAG grew. BHCAG also created and continues to fund the Institute for Clinical Systems Integration, a nonprofit organization that assists the Choice Plus provider network with quality initiatives.

Although pleased with the performance of Choice Plus, BHCAG implemented a new, more competitive purchasing strategy in 1996, after analyses indicated that more efficient provider groups were, in effect, subsidizing less efficient ones. BHCAG was concerned that incentives to improve quality, service, and cost were insufficient at the network level and that consolidation in the Minnesota managed care market was stifling competition. In addition, BHCAG believed that substantial overlaps in provider networks indicated that plans were not competing on the basis of quality. The alliance hoped that its direct contracts with provider groups would create stronger incentives to provide care efficiently.

Under its new "enhanced competitive model," BHCAG contracts directly with "care systems," defined as "primary-care centered health systems with affiliated specialty, hospital, and allied professional arrangements." Any care system that meets BHCAG quality standards is eligible to participate, but primary care providers may belong to only one care system. BHCAG plans to give employees comparative information about care systems and incentives to choose cost-effective systems.

In order to foster beneficial competition among provider groups, BHCAG has also adopted a novel version of the ACG system. Networks bidding to serve BHCAG member employees are given three years of claims data on the covered population and asked to submit claims targets based on a standard

benefit package and enrollee mix. BHCAG then sets a fee schedule for each network based on its target. Claims experience is adjusted quarterly using ACGs, and the fee schedule is revised to reflect experience over the past 12 months. This adjustment process is more sophisticated than that used by Gateway because it employs diagnostic information. Although its self-insured status prevents BHCAG from recovering losses or gains from the networks, the alliance adjusts enrollee premiums based on the claims target of the network chosen.

CONCLUSIONS

State agencies and employers are just beginning to deal with the issue of risk selection, and very few are using risk adjustment at the present time. As outlined in the table, the leading methods range in sophistication from prospective diagnostic adjustment, on the high end, to risk assessment and premium negotiation, on the low end.

Surprisingly, no pattern has emerged in the types of risk adjustment being adopted by particular types of purchasers. Effective risk adjustment certainly demands a capacity for complex data analysis, and three of the five example organizations shown in the table (the Maryland and Colorado Medicaid programs and PBGH) have close affiliations with university-based risk adjustment experts. Even so, such affiliations do not guarantee implementation, while two organizations have succeeded in implementing programs without assistance from university experts. Outside funding to pursue risk adjustment is no panacea; PBGH's risk adjustment research, despite external support, did not produce a risk adjuster that has been implemented.

What can other entities, including the Medicare program, learn from the efforts of these pioneers? First, as the paucity of working risk adjustment schemes suggests, implementing risk adjustment is difficult. Few entities are ahead of the Medicare program in using diagnosis-based riskadjustment, the best method currently available. On the contrary, the majority of large purchasers of health care are less advanced than either the Medicare program or those Medicaid programs that have implemented age, gender, and eligibility information to adjust their capitation rates.

Second, some purchasers have proven that diagnostic risk adjustment systems can be implemented successfully. Health plans contracting with these purchasers have agreed to provide the data needed for diagnostic risk adjustment and seem capable of doing so. Also, less sophisticated but still valuable systems, such as high-cost condition pools, seem easier to implement than comprehensive risk adjustment systems, perhaps because they require less data and are easier to understand. Another method, the "ceding" of high-cost cases back to fee-for-service coverage, has not been tried but is similar to reinsurance and should prove relatively easy to implement.

Finally, as shown in Colorado, as sicker and disabled populations move into Medicaid managed care, the need for risk adjustment increases dramatically. The Medicare program and Medicaid agencies in particular would stand to gain from careful consideration of Colorado's experience before enrolling disabled beneficiaries in managed care plans. Indeed, the disabled population is more predictably heterogeneous than are either the low-

income women and children Medicaid population or the commercial population. As a result, implementing risk adjustment methods for disabled Medicaid managed care enrollees is particularly urgent.

Footnotes

1 See, for example, Marilyn Moon and Karen Davis, "Preserving and Strengthening Medicare," Health Affairs 14(4):31-46, Winter 1995.

2 Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John Chapman, "Risk Adjustment and Medicare," Health Affairs 16(5):26-43, September/October 1997. See also Joseph P. Newhouse, "Risk Adjustment: Where Are We Now?" Inquiry, Summer 1998 (forthcoming).

3 Gail Jensen et al., "The New Dominance of Managed Care: Insurance Trends in the 1990s," Health Affairs 16(1):125-36, January/February 1997.

4 Personal communication with Deborah Freund, Ph.D., Vice-Provost, Indiana University, 1997.

5 Richard Kronick, Zhiyuan Zhou, and Tony Dreyfus, "Making Risk Adjustment Work for Everyone," Inquiry 32(1):41-55, Spring 1995. On age and gender as predictors in the private employer context, see Joseph P. Newhouse, Willard G. Manning, Emmett B. Keeler, and Elizabeth Sloss, "Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization," Health Care Financing Review 10(3):41-54, Spring 1989.

6 Arleen Leibowitz, Joan Buchanan, and Joyce Mann, "A Randomized Trial to Evaluate the Effectiveness of a Medicaid HMO," Journal of Health Economics 11:235-57, 1992.

7 Deborah Freund et al., "Evaluation of Medicaid Capitation Demonstrations," Health Care Financing Review 10(3):81-97, Spring 1989.

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9 Randall P. Ellis, Gregory Pope, Lisa Iezzoni, John Ayanian, David Bates, Helen Burstin, and Arlene Ash, "Diagnosis-based Risk Adjustment for Medicare Capitation Payments," Health Care Financing Review 17(3):101-28, Spring 1996; Jonathan Weiner et al., "Risk-Adjusted Capitation Rates for Medicare Using Ambulatory and Inpatient Claims Diagnoses," Health Care Financing Review 17(3):77-99, Spring 1996.

10 Richard Kronick, Tony Dreyfus, Lora Lee, and Zhiyuan Zhou, "Diagnostic Risk Adjustment for Medicaid: The Disability Payment System," Health Care Financing Review 17(3):7-33, Spring 1996.

11 Newhouse et al., "Risk Adjustment and Medicare," 1997.

12 Richard Kronick and Tony Dreyfus, "The Challenge of Risk Adjustment for People with Disabilities: Health-Based Payment for Medicaid Programs," Center for Health Care Strategies, Inc., November 1997.

13 The Center for Health Program Development and Management at the University of Maryland, Baltimore County, and the Actuarial Research Corporation contributed to the development of the rates. The eight health plans participating in the program were also involved in the rate-setting process.

14 Gordon R. Trapnell, "Maryland Medicaid Managed Care Program (1115 Waiver): Development of MCO Rates-Methodology," Actuarial Research Corporation, November 1, 1996.

15 The description of Colorado's program is drawn from Kronick and Dreyfus, "The Challenge of Risk Adjustment for People with Disabilities," 1997.

16 Daniel Dunn, "Case Studies of Health Risk Adjustment: What Can Be Learned from Experience to Date?" Inquiry, Summer 1998 (forthcoming).

17 Among respondents to a Lewin Group survey (40 states), 90 percent

collect cost and utilization data. Lewin-VHI, "States as Purchasers: Innovations in State Employee Health Benefit Programs," report to the National Institute of Health Care Management, April 1995.

18 Lewin-VHI, "States as Purchasers," 1995.

19 Personal communication with Margaret Stanley, Assistant Executive Officer, CalPERS, 1997.

20 Alpha Center, "Implementing Diagnostic Risk Adjustment in an Employed Population," HCFO News and Progress, March 1997.

21 Jana Sansbury, "Washington State May Risk-Adjust Pay to Plans Based on Health Status of Public Employees," State Health Watch, February 1997.

22 Dunn, "Case Studies of Health Risk Adjustment," 1998.

23 Carole Lee and Deborah Rogal, "Risk Adjustment: A Key to Changing Incentives in the Health Insurance Market," Alpha Center, March 1997.

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26 Health Insurance Plan of California, "Risk Assessment and Risk Adjustment Calculations: Results for 1997-98 Contract Year," December 10, 1996.

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31 Presentation by Patricia Powers, Executive Director, and Karen Shore, Research Analyst, Pacific Business Group on Health, September 26, 1996.

32 Pacific Business Group on Health, "Developing Practical Risk Assessment Tools for Large Employers and Testing Risk Adjustment Approaches in Health Care Purchasing," February 25, 1997.

33 Personal communication with Karen Shore, Research Analyst, Pacific Business Group on Health, September 15, 1997.

34 Dunn, "Case Studies of Health Risk Adjustment," 1998.

35 Buyer's Health Care Action Group, 1996 Annual Report.

36 Personal communication with Steve Wetzell, Executive Director of Policy and Public Affairs, Buyer's Health Care Action Group, 1997.

37 Newhouse et al., "Risk Adjustment and Medicare," 1997.

38 Kronick et al., "Making Risk Adjustment Work for Everyone," 1995.

Speakers

COMMITTEE HEARING ON SB 162

Date 4/12 Place

NAME: JUDITH RYAN

Business Address: One Eagle Sq.

City: Concord Phone:

REPRESENTING: Bi-State PCA

WISH TO SPEAK: YES ___ NO ✓ Time Needed:

Supporting Bill: Yes Opposing Bill:

PLEASE LEAVE COPY OF ANY PREPARED STATEMENT WITH COMMITTEE CLERK

COMMITTEE HEARING ON SB 162

Date 4/12/99 Place Concord

NAME: Suzanne Amidon

Business Address: 125 Airport Rd

City: Concord NH Phone: 225-0900

REPRESENTING: NH Hospital Assn

WISH TO SPEAK: YES ✓ NO ___ Time Needed: 3 min

Supporting Bill: ✓ Opposing Bill:

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COMMITTEE HEARING ON SB 162

Date 4/12/99 Place Rm 206

NAME: Tom Hoyle

Business Address: 93 Stiles Rd

City: Salem, NH Phone: 8988883

REPRESENTING: NHAHC

WISH TO SPEAK: YES ✓ NO ___ Time Needed: 5 min

Supporting Bill: ___ Opposing Bill: X

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COMMITTEE HEARING ON SB162

Date 4/12/99 Place Senate Insurance

NAME: Yvonne Nanasi

Business Address: _____

City: _____ Phone: 695-7354

REPRESENTING: BCBSNH

WISH TO SPEAK: YES X NO ___ Time Needed: 2 min.

Supporting Bill: X Opposing Bill: _____

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COMMITTEE HEARING ON SB 162

Date 4/12/99 Place LOB 206

NAME: Alex Feldvebel

Business Address: 56 Old Suncook's Rd.

City: Concord Phone: 271-2261

REPRESENTING: NH Insurance Dept.

WISH TO SPEAK: YES X NO ___ Time Needed: 4 min.

Supporting Bill: X Opposing Bill: _____

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COMMITTEE HEARING ON SB 162

Date 4/12 Place 206

NAME: R David Larrivee

Business Address: 15 Constitution Drive

City: Bedford NH Phone: 471-4317

REPRESENTING: Tufts Health Plan

WISH TO SPEAK: YES ✓ NO ___ Time Needed: 10 minutes

Supporting Bill: _____ Opposing Bill: X

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COMMITTEE HEARING ON SB 162

Date 4/12/99 Place LOB 206-208

NAME: Katharine Enequist

Business Address: 122 ND Main ST

City: Concord Phone: 224 5388

REPRESENTING: Business & Industry Assoc

WISH TO SPEAK: YES ___ NO X Time Needed: ___

Supporting Bill: X Opposing Bill: ___

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COMMITTEE HEARING ON SB 162

Date April 12 99 Place RA 206

NAME: PAULA ROGERS

Business Address: 3 MAPLE

City: CONCORD NH Phone: ___

REPRESENTING: HIAA

WISH TO SPEAK: YES ___ NO X Time Needed: ___

Supporting Bill: ___ Opposing Bill: Submitted written Comment

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HAS TO LEAVE BY 10:30

COMMITTEE HEARING ON SB 162 Purchasing Alliances

Date 4/12/99 Place ___

NAME: Lori Real

Business Address: 129 Pleasant St.

City: Concord. Phone: 271-3676

REPRESENTING: Health & Human Services

WISH TO SPEAK: YES X NO ___ Time Needed: 5 Min MAX

Supporting Bill: Yes Opposing Bill: ___

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COMMITTEE HEARING ON SB 162

Date 4/12 Place

NAME: Jonathan Stewart

Business Address: Littleton NH

City: Phone: 444-2464

REPRESENTING: North County Health Consortium

WISH TO SPEAK: YES ✓ NO Time Needed:

Supporting Bill: ✓ Opposing Bill:

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COMMITTEE HEARING ON SB 162

Date 4/12/99 Place

NAME: HAROLD SULLIVAN

Business Address: 15 CONSTITUTION DR.

City: BEDFORD, N.H. Phone: 669-0032

REPRESENTING: N.H. ASSN OF LIFE UNDWTRS.

WISH TO SPEAK: YES ✓ NO Time Needed: 2:00

Supporting Bill: Opposing Bill: ✓

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COMMITTEE HEARING ON SB 162

Date 4-12-99 Place 208 NH 204

NAME: GEORGE BALD

Business Address: 172 Pembroke Rd

City: Concord, NH Phone: 271-2411

REPRESENTING: Department of Resources & ED

WISH TO SPEAK: YES ✓ NO Time Needed: 1 MIN

Supporting Bill: ✓ Opposing Bill:

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COMMITTEE HEARING ON SB 162

Date 4/12/99 Place Rm 206-208

NAME: William S. Bartlett Jr

Business Address: 2 Eagle Sq

City: Concord NH Phone: 228-2466

REPRESENTING: Harvard Pilgrim Healthcare

WISH TO SPEAK: YES ✓ NO Time Needed: 2 min

Supporting Bill: _____ Opposing Bill: X

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COMMITTEE HEARING ON SB162

Date 4/12/99 Place LOB-206-208

NAME: Karen Hicks

Business Address: State House

City: _____ Phone: 271-2121

REPRESENTING: Governor Shaheen

WISH TO SPEAK: YES ✓ NO Time Needed: 1 minute

Supporting Bill: _____ Opposing Bill: _____

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COMMITTEE HEARING ON SB162

Date 4/12/99 Place LOB 206-208

NAME: Jon Breslen

Business Address: 10 Bartlett St.

City: Suncook (Allenstown) Phone: 485 9558

REPRESENTING: Suncook Trim Corporation

WISH TO SPEAK: YES ✓ NO Time Needed: 10 min. (or less)

Supporting Bill: ✓ Opposing Bill: _____

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COMMITTEE HEARING ON SB 162

Date _____ Place _____

NAME: Caroline McCarley

Business Address: _____

City: _____ Phone: _____

REPRESENTING: SPG

WISH TO SPEAK: YES ___ NO X Time Needed: _____

Supporting Bill: X Opposing Bill: _____

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COMMITTEE HEARING ON SB 162

Date 4-12-99 Place 203 206-208

NAME: Sen. Dan Fraser

Business Address: Dist #4

City: _____ Phone: _____

REPRESENTING: Sponsor

WISH TO SPEAK: YES X NO ___ Time Needed: 3 mins

Supporting Bill: a Opposing Bill: _____

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Committee Report

SB162 Docket

Next|Previous|Results List|Bill Status

Bill Title: (2nd New Title) authorizing licensure and regulatory oversight of voluntary small employer health insurance purchasing alliances.

Date	Body	Description
2/11/99	**S**	Introduction and referring to Insurance 2/11/99; SJ 4, P 43
3/5/99	**S**	Hearing, 4/5/99, Room 306-308, LOB, 9:00 a.m.
3/29/99	**S**	Rescheduled Hearing, 4/12/99, Room 306-308, LOB, 8:30 a.m.
5/12/99	**S**	Committee Report, Ought to Pass W/Amendment, 5/13/99
5/12/99	**S**	Committee Amendment, {1194}, (New Title), SC 30 P9
5/13/99	**S**	Ought to Pass W/Amendment, {1194}, (New Title), AA, VV, OT3rdg, MA, VV; SJ 18, P 450-459
5/13/99	**H**	Introduced and ref to Commerce; HJ54, p1418
5/18/99	**H**	Copy to Chairman on 5/18/1999 due on
5/19/99	**H**	Hearing June 1 10:30 Rm302,LOB
6/9/99	**H**	Subcom work session June 17 10:30 Rm302,LOB
6/17/99	**H**	Maj Report RE-REF for June 22 (vote 15-1;CC)
6/22/99	**H**	Re-Referred to Commerce committee; HJ73, p1873
8/12/99	**H**	Re-Ref Subcom work session Sep 8 11:30 Rm302,LOB
9/8/99	**H**	Re-Ref Subcom work session Sep 15 11:30 RM302,LOB
9/15/99	**H**	Rerefer subcom work session Oct 6 10:00 Rm302,LOB
10/6/99	**H**	Re-Ref Subcom work session Oct 13 10:00 RM302,LOB
10/13/99	**H**	Re-Ref Subcom work session Oct 19 1:30 RM302,LOB
11/1/99	**H**	RE-REF Maj Report OTP/AM for 1/5/2000 (vote 16-0; CC)
11/1/99	**H**	Prop Comm Am{2182}(New Title); HC93, p2306-2307
1/5/00	**H**	Passed with Am; HJ5, p108 + 164
1/13/00	**S**	Sen.Wheeler Concurs With House Amendment{2182}[New Title],. MA, VV; SJ 1, Pg.33
1/13/00	**S**	Enrolled; SJ 1, Pg.37
1/27/00	**H**	Enrolled; HJ14, p348
2/2/00	**S**	Signed by the Governor on 2/2/2000 Eff: 1/1/2001* Chap: 0002
2/2/00	**S**	*multiple eff. dates - See Chapter

**Docket Abbreviation Explanations

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