Bill as Introduced

HB 470 – AS INTRODUCED

2003 SESSION

03-0750
01/09

HOUSE BILL ***470***

AN ACT relative to health insurance providers.

SPONSORS: Rep. Gilman, Graf 9; Rep. Buhlman, Hills 66; Rep. Sorg, Graf 11; Sen. Martel, Dist 18

COMMITTEE: Commerce

ANALYSIS

This bill requires health insurers to accept as providers any provider who is in good standing with the appropriate licensing authority.

The bill also requires health insurers to keep a provider's personal information confidential.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 470 – AS INTRODUCED

03-0750
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Three

AN ACT relative to health insurance providers.

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

1 New Sections; Health Insurers; Providers. Amend RSA 400-A by inserting after section 15-a the following new sections:

400-A:15-b Providers Required to be Accepted.

I. Notwithstanding any provision of law to the contrary, health insurers shall offer to and accept as providers any provider who is in good standing with the state licensing board whose specialty of practice is within the scope of services covered by the health plan.

II. Health insurers shall not terminate a provider without cause and due process. Any such termination may be appealed to the insurance commissioner. Providers may withdraw voluntarily from insurance rosters at any time. Such providers shall be reinstated voluntarily, if they desire, upon reapplication, at the next fiscal year renewal.

III. The provisions of this section shall apply to group hospital and medical expense policies subject to RSA 415, group health service plan contracts issued pursuant to RSA 420-A, and to health maintenance organization policies and plans issued pursuant to RSA 420-B.

400-A:15-c Confidentiality of Provider's Personal Information. to protect entire prov.

I. Health insurers and other third party payors shall not divulge, in any manner, the personal information of a provider such as the provider's home address, date of birth, or social security number.

II. The provisions of this section shall apply to group hospital and medical expense policies subject to RSA 415, group health service plan contracts issued pursuant to RSA 420-A, and to health maintenance organization policies and plans issued pursuant to RSA 420-B.

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

Amendments

Rep. Brady, Coos 2
March 14, 2003
2003-0728h
01/09

Amendment to HB 470

Amend the bill by replacing all after the enacting clause with the following:

1 New Section; Health Insurers; Providers. Amend RSA 400-A by inserting after section 15-a the following new section:

400-A:15-b Confidentiality of Provider's Personal Information.

I. Health insurers and other third party payors shall not display a medical provider's home address, date of birth, or social security number on documents provided to subscribers for the purpose of claim payment unless the provider has provided that information for the purposes of claim payment.

II. The provisions of this section shall apply to group hospital and medical expense policies subject to RSA 415, group health service plan contracts issued pursuant to RSA 420-A, and to health maintenance organization policies and plans issued pursuant to RSA 420-B.

2 Effective Date. This act shall take effect January 1, 2004.

2003-0728h

AMENDED ANALYSIS

The bill requires health insurers to keep a provider's personal information confidential.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 470 Date 2-5-03

Committee Commerce

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
PAULA Minnehan	25 Airport Rd	225 0500	New Hampshire Hospital Assoc		✓
Gina Balkus	Lebanon NH	629-1256	Dartmouth-Hitchcock		✓
Liz Murphy	2 Eagle Sq	228 2966	Cigna		✓
Michael Dennehy	2 Eagle Sq	228 2966	HIAA		✓
James Shanalach	105 Pleasant ST.	271-6100	Div. of Alcohol and Drug Abuse Prevention	✓	
Reg Rep Peg Gratton	HANOVER	989 3092	DIST 13	✓	

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 470

BILL TITLE: relative to health insurance providers.

DATE: February 5, 2003

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

Time Adjourned: 3:45 pm

(please circle if present)

Committee Members: Reps. Hunt, L. Fraser, Francoeur, Belanger, Langley, DiFruscia, D. Flanders, Spiess, Holden, Liebl, Quandt, Charles Clark, Brady, Scamman, Stepanek, Reardon, Kathleen Taylor, Meader, DeStefano, Vachon and Kopka.

Bill Sponsors: Reps. Gilman, Buhlman, Sorg and Sen. Martel

TESTIMONY

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

***Rep. Mike Gilman, prime sponsor** – Introduced the bill. See written testimony pages 1-2, paragraphs I, II and III.

***Dr. Deborah Warner, representing self** – Suggested added language to line 15 of the bill. See written testimony. Introduced the concept of "any willing provider". Stressed the need to expand the list of available providers. 1) Increased supply of doctors 2 Improved access to care 3) Remove the threat of termination from a provider list. 4) Would eliminate artificial constraints of trade. The second part of the bill deals with confidentiality. Requires that insurers respect privacy of doctors and patients.

Q: Rep. Fraser – Have you ever been terminated from a panel by an insurer? Or do you know anyone who has?

A: No, I have not been terminated, but I have heard from others who have without cause.

Q: Rep. Mark Brady – Do you know of specific situations where doctors have been stalked by patients?

A: Yes, it happens on a regular basis, particularly with mental health specialists.

Rep. Judson Dexter – Supports the bill. Has been an eye doctor for 30 years. The issue of access or approval to medical panels is very real. Insurers have sole discretion on who they will accept on their panel. If a patient can't get reimbursed for a procedure because the doctor is not approved, then the patient will go elsewhere. The reality is that insurers can and do steer business to preferred providers.

Alex Feldvebel, NH Insurance Department – Opposes the bill. Any willing provider provisions would have an inflationary impact, and would undermine insurer efforts to contain costs. Need to balance the issues of access to health care versus the cost of services.

Q: Rep. Stephen De Stefano – Would you have a problem with the second part of this bill, concerning privacy.

A: I would want to check with HIPPA first.

***James Monahan, NH Chiropractic Association** – Speaking in favor of the legislation. Submitted written testimony.

***Yvonne Nanasi, BC/BS ANTHEM** – Opposes the bill. See written testimony. The cost of the "any willing provider" provision is the cost of credentialling new practitioners. Estimated at $75,000 for just mental health providers. The real costs are administering the provider relationship.

***Bonnie Packard, Harvard Pilgrim** – Opposes the bill. See written testimony.

Respectfully Submitted:

Paul D. Spiess, Clerk

Sub-Committee Actions

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 470

BILL TITLE: relative to health insurance providers.

DATE: March 18, 2003

Subcommittee Members: Reps. Liebl, Brady & Kopka

Comments and Recommendations: Amendment adopted.

Amendments:

Sponsor: Rep. Brady	OLS Document #:	2003	0728h
Sponsor: Rep.	OLS Document #:		
Sponsor: Rep.	OLS Document #:		

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

Moved by Rep. Brady

Seconded by Rep. Kopka

Vote: 3-0

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

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. George J. Liebl
Subcommittee Chairman/Clerk

Sub-Committee Minutes

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 470

BILL TITLE: relative to health insurance providers.

DATE: March 10, 2003

Subcommittee Members: Reps. Liebl, Kopka, Brady

Comments and Recommendations: Yvonne Nanasi stated social security numbers equal tax ID number as well (sole freestanding provision). Representative Gilman amendment forthcoming. Working with Yvonne Nanasi. Will reschdule subcommittee.

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

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

Moved by Rep.

Seconded by Rep.

Vote:

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

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. {Type NAME}
Subcommittee Chairman/Clerk

3/10/03
HB 470
Subcommittee Hearing

Rep. Liebl - opened meeting

Yvonne Nanasi -
① SSN = tax id # as well (sole freestanding prov.)
② " used to do credentialing & hc. providers
in house administrative purposes for Bc/BS

Ca - law -> has phase-in which NH HB

affect -> ① providers will have to transition
from use of SSN -s to Tax ID
② work w/ NCQA -> how to do credentialing

Benefit Statement - displays SSN which
Given patient access to ~~dear~~ doctors SSN
(ie) to stalk, etc.

Yvonne - on Privacy Component of Bill
-> focus bill on EOB (explanation of benefits)
-> effective 1/1/04

Rep. Liebl - must be careful w/ legislating
specific policy
- Asked Rep. Gilman if he would redraft : an amendment

Testimony

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New Hampshire Insurance Department

Memo

To: Representative George J. Liebl, Commerce

From: Maureen Hartsmith, Life & Health Compliance Manager

CC: Alex Feldvebel, Deputy Insurance Commissioner

Date: 2/12/03

Re: House Bill 544

New Hampshire does not have a mandate for Durable Medical Equipment coverage. There are regulations of minimum standards for accident and health insurance benefits that would provide some durable medical equipment coverage under the Major Medical category for both individual and group coverage.

Ins 1901.03 (b)(4)h. requires, ..."and rental and/or purchase of durable medical equipment required for therapeutic use."

The benefit is not further defined so long as there is some coverage is provided the requirement is satisfied.

I have attached a copy of the minimum standards for accident and health insurance benefits, Ins 1901.03.

Please let me know if I can be of further assistance.

New Hampshire Regulations
NEW HAMPSHIRE CODE OF ADMINISTRATIVE RULES
RULES OF THE INSURANCE COMMISSIONER
Chapter Ins 1900 -- ACCIDENT AND HEALTH INSURANCE
Part Ins 1901. Minimum Standards for Accident and Health Insurance

Statutory Authority: RSA 400-A:15; RSA 415-A:2; RSA 420-A:20; and RSA 420-B:21

Ins 1901.03 Minimum standards for accident and health insurance benefits

NEW REGULATORY ACTIVITY 3

FORMER CITATION 19(r)

(a) The following minimum standards for benefits are prescribed for the categories of coverage specified in the following subsections. Unless otherwise specifically stated, no policy of accident or accident and health insurance shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for any one of the categories of coverage listed in subparagraphs (1) through (7). But, nothing in this section shall preclude the issuance of any policy or contract which combines 2 or more of the categories of coverage listed in subparagraphs (1) through (7). However, in the event that any policy or contract delivered or issued for delivery in this state shall include 2 or more categories of coverage, it shall be required to meet the prescribed minimum standards with respect to each category of coverage so included.

(b) The above notwithstanding, if the commissioner shall find that a policy not meeting the prescribed minimum standards will nevertheless be in the public interest, the commissioner may approve such policy for delivery or issue for delivery in this state subject to whatever conditions the commissioner may deem reasonable. Nor shall this section apply to any group or blanket policy where any portion of the premium is paid from an employer's funds or from funds contributed by an employer. Neither shall this section be interpreted to preclude the possibility of approval of certain policy or contract forms that are not classifiable within the specified categories of coverage provided such policies otherwise comply with the provisions of this part and other applicable laws and parts.

(1) "Basic hospital expense coverage" when included as a category of coverage in a policy shall provide coverage subject to no deductible in excess of $100 for a period or not less than 30 days for any continuous hospital confinement of each covered person for services rendered while confined in a hospital, or in the case of a non-profit service corporation, for services rendered while confined in a member hospital, for necessary treatment because of sickness or injury for at least:

a. Daily room and board, consisting of bed and board, including general nursing care and special diets in an amount not less than the lesser of a specified percentage of the average semiprivate room rate in the community where the insured resides or a specified dollar amount per

day.

b. Miscellaneous hospital services, during each period of continuous hospital confinement for which room and board charges are payable, in an amount not less than a specified amount or percentage of the charges incurred up to a maximum limit for at least:

1. the use of operating, recovery and cystoscopic rooms and equipment;

2. the use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;

3. diagnostic and therapeutic items such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes for care in the hospital, and administration thereof, but not including those which are not commercially available for purchase and readily obtainable by the hospital;

4. dressing and plaster casts;

5. supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person; and

6. any medical services or supplies which are customarily provided by hospitals unless specifically excluded in the insurance or subscriber contract or in the individual certificates issued in connection with group insurance.

c. Outpatient services, consisting of:

1. hospital services on the day surgery is performed to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital;

2. hospital services rendered within 24 hours after an accidental injury in an amount up to a maximum of not less than a specified dollar amount per each such injury; and

3. x-ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital up to a specified dollar maximum per disability or per calendar or policy year.

(2) "Basic medical-surgical expense coverage" when included as a category of coverage in a policy shall provide coverage for service rendered by a physician, or in the case of a non-profit service corporation a participating physician, to each covered person for sickness or injury for at least the following:

a. Surgical services consisting of operating and cutting procedures for the treatment of a sickness or injury, and endoscopic procedures including any pre- or post-operative care usually rendered in connection with such operation or procedure, in an amount no less than:

1. a specified percentage of the reasonable charges; or

2. if specified in dollar amounts, a fee schedule based on an acceptable relative value scale of surgical procedures up to a specified dollar maximum for any one procedure.

b. Anesthetic services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician performing the surgical service or his assistant, in an amount not less than the lesser of a specified percentage of the reasonable charge, which percentage shall be the same as that specified for surgical services, or 15% of the benefit provided as a specified dollar amount for that operation or procedure pursuant to Ins 1909.03(b)(2)a.

c. In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical or pregnancy care is required, in an amount not less than the lesser of:

1. a specified percentage of the reasonable charges; or

2. a specified dollar amount per day, in either case for not less than 30 days per each continuous period of confinement.

(3) "Hospital confinement indemnity coverage" when included as a category of coverage in a policy shall provide daily benefits for hospital confinement on an indemnity basis, with or without an elimination period, in an amount not less than the dollar amount per day specified in the policy and for not less than 31 days during any one period of confinement for each person insured under the policy.

(4) "Major medical expense coverage" when included as a category of coverage in a policy shall provide hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $10,000; co-payment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefit provided by such underlying insurance, for each covered person for at least:

a. Daily hospital room and board expenses, as defined in Ins 1901.03(b)(1)a. of this part, prior to application of the co-payment percentage, for not less than a specified dollar amount per day for a period of not less than 31 days during continuous hospital confinement.

b. Miscellaneous hospital services, as defined in INS 1901.03(b)(1)b. prior to application of the co-payment percentage, for an aggregate maximum of not less than that specified in the policy as either an aggregate dollar amount or a multiple of the daily room and board rate when such rate is specified in dollar amounts.

c. Surgical services, as defined in INS 1901.03(b)(2)a. prior to application of the co-payment percentage, for a maximum of not less than

a specified dollar amount for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount.

d. Anesthetic services, as defined in INS 1901.03(b)(2)b. prior to the application of the co-payment percentage, for a maximum of not less than 15% of the covered surgical fees, or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used in the surgical schedule.

e. In-hospital medical services, as defined in INS 1901.03(b)(2)c. with minimum dollar amounts per visit, prior to the application of the co-payment percentage, equal to not less than a specified dollar amount per visit covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than the dollar amount specified.

f. Outpatient services, provided by a hospital, to include:

1. hospital services on the day surgery is performed;

2. hospital services rendered within 24 hours after accidental injury, and;

3. diagnostic x-ray and laboratory services, radiation therapy and hemodialysis ordered by a physician.

g. Out-of-hospital care, consisting of:

1. physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury; and

2. diagnostic x-ray and laboratory services, prescription drugs, radiation therapy and hemodialysis ordered by a physician.

h. Prosthetic appliances, meaning artificial limbs or other prosthetic appliances, except replacements thereof, and rental and/or purchase of durable medical equipment required for therapeutic use;

i. Benefits for other medical expenses to include at least 3 of the following:

1. The services of a registered graduate nurse, R.N., other than a nurse who ordinarily resides in the insured's home or is a member of the insured's or the insured spouse's family;

2. Physical therapy;

3. Professional ambulance service when used to transport the individual from the place where he is injured by an accident or stricken by a disease to the first hospital where treatment is given;

4. Convalescent nursing home care;

5. Treatment for functional nervous disorders, and mental and emotional disorders; or

6. Unless otherwise prohibited by law, the above benefits may be subject to a co-insurance percentage of 50% and may be further limited by internal limits on such covered charges and a maximum limit applicable to each such covered charge.

(5) "Disability income protection coverage" when included as a category of coverage in a policy shall provide for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from sickness or injury or a combination thereof.

(6) "Accident only coverage" when included as a category of coverage in a policy shall provide coverage, either singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident.

(7) "Specified disease coverage" when included as a category of coverage in a policy shall provide coverage for each person insured under a policy for a specifically named disease, or diseases, or for procedures or treatments unique to specified diseases. This category of coverage will be permitted as the only category of coverage provided by a policy of accident and health insurance when the policy is issued under a franchise plan. For the purposes of this part, accident and health insurance under a franchise plan is considered to be that insurance which is defined in and which complies with all requirements of RSA 415:19. When the "specified disease" category of coverage is provided in any policy of accident and health insurance that is not issued under a franchise plan, such policy must also provide insurance which meets the minimum standards stated under INS 1901.03(b) for at least one of the following categories of coverage -- basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, or major medical expense coverage. Whenever provided in any policy, "specified disease coverage" shall be in addition to any other benefits provided by the policy. It is further provided, however, that the commissioner of insurance may approve additional methods of marketing for this category of coverage, if it is deemed to be in the public interest.

(8) "Specified accident coverage" when included as a category of coverage in any policy shall provide coverage for a specifically identified kind of accident, or accidents, for each person covered under the policy, either singly or in combination for death, dismemberment, disability, or hospital and medical care caused by the accident, or accidents, specified.

HISTORY Doc. No. 1900, eff. 1-1-82; Doc. No. 2582, amd. eff. 1-23-84; Doc. No. 4287, read. and eff. 7-1-87; Doc. No. 5656, read. and eff. 7-1-93.

CROSS REFERENCE 400-A:15; 415-A:2; 415:19; 420-A:20; 420-B:21

CITED BY BULLETIN OF MAY 3, 1990

DATE AMENDED 1984; 1987; 1993

SUBJECT CATEGORY 060 - Health insurance / insurers
300 - The policy

DEFINITIONS Basic hospital expense coverage; Basic medical surgical

expense coverage; Hospital confinement indemnity coverage; Major medical expense coverage; Disability income protection coverage; Accident only coverage; Specified disease coverage; Specified accident coverage

INDEX

Health insurance and Benefits and Standards
Policy provisions and Health insurance
Basic medical expense coverage and Benefit limitations and Health insurance
Hospital confinement indemnity coverage and Benefit limitations and Health insurance
Major medical coverage and Benefit limitations and Health insurance
Specified disease policies and Benefits and Health insurance

INFORMATION TYPE TEXT

DOCUMENT ID NH REGS RG Ins 1901.03

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Psychologist
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E-Mail: JPBrownJr@AOL.com

February 5, 2003

Honorable John B. Hunt, Chairman
Commerce Committee
New Hampshire House of Representatives

RE: Support for HB 470, An Act relative to health insurance providers

Chairman Hunt:

I would like to convey to you and the members of your committee my unqualified support of HB 470. I would be honored to testify to the following written input and respond to any questions but I am otherwise occupied supporting HB 473, a bill drafted by me to make the Board of Mental Health Practice better able to fulfill its vital screening role in HB 470.

I am a psychologist in solo private practice in Sullivan County where consumer choices are considerably more limited than in more urban or socioeconomically advantaged areas. Much of my private practice time in Sullivan County has been spent as the only clinical psychologist working full time in Sullivan County who is not employed by the local community mental health center.

Several years ago, at a time when I was on the provider panels of Healthsource, Matthew Thornton, and all other locally active HMO's with the notable exception of one – Blue Choice, I drafted an "any willing provider" LSR that was sponsored by Senator Disnard. My version required insurance carriers to publicly specify criteria for membership on their mental health provider panels and to then accept as providers anyone who met those published criteria. The bill would have permitted the carriers to specify criteria more restrictive than those required by mental health regulatory boards – such as "demonstrated commitment to using treatment approaches scientifically shown to be cost-effective" and to set fees as low as the market would bear. It would not have permitted Blue Choice to continue its essentially exclusive contract with its back-room consortium of community mental health centers in which unlicensed bachelor's level providers could be paid for services in a community mental health center that the HMO would not pay for if provided by the most highly qualified of doctoral level psychologists outside the CMHC. My bill offended just about everyone and died an ignominious death in committee.

Flash forward, past five years that the Board of Mental Health Practice is trying to forget, during which I was not in practice, and I am again the only clinical psychologist working full time in Sullivan County outside of West Central Behavioral Health, the very

dominant local CMHC that has increasingly come to legislative attention. HMOs like Healthsource and Matthew Thornton have been gobbled up by much larger entities like Cigna and Anthem . Neither Cigna nor Anthem will accept me on their HMO provider panels so the many Sullivan County HMO subscribers who would prefer to obtain services from me are forced to either see a less highly trained/experienced provider, leave the county for services or forego their otherwise excellent health care coverage and pay me out of pocket.

Decisions by Cigna and Anthem to exclude me from their provider panels has absolutely nothing to do with any conceivable criteria related to licensure, training, demonstrated skills, or even fees that I am willing to accept. My doctoral training in the 70's, seven years as an active duty psychologist in the U.S. Navy, and many subsequent years as a civilian psychologist in small town New Hampshire have all been dedicated to effective and cost-efficient services supposedly valued by HMOs. For nearly three years I wrote a weekly newspaper column in Newport's Argus – Champion giving practical, family- and community- based mental health advice and very publicly criticizing ineffective and inefficient professional services. I worked in a neighborhood of "receiver" towns and gave away more billable services than I care to admit because I was willing to forgo higher fees and grosser annual incomes. The only reason why I can not be an HMO provider now is explained by the attached letter from Cigna: they have enough providers in my area. Anthem has declined to give me any written explanation of why my repeated requests to join their HMOs have been unsuccessful. To Anthem's credit, however, they may control the only HMOs operating in this state where panel membership decisions concerning mental health care providers are made in-state.

The Sullivan County model of HMO mental health care resembles in too many respects that found throughout this state. Including mental health care coverage under HMOs has never been about ensuring either the best or the most affordable services. It has been about squeezing costs as much as possible while incurring a minimum of administrative overhead and litigation exposure. It has been about denying services, rationing services, and discouraging services rather than ensuring that all appropriate services are being delivered as cost-efficiently and effectively as possible by the most competent and respected of mental health care professionals. When HMOs have what they believe are enough providers in any given area – without any original effort to ensure participation of the most effective providers in that area - it requires an act of the legislature to force them to accept any new providers. Since provider panels are meant to act as monopolies to deny participation of even the most competitive of outsiders – including outsiders with lower costs and better services – such an act of the legislation is called for.

We are, if anything, in this age of HMO carve-outs of mental health services to huge out-of-state entities, moving farther away from delivery systems that promise more affordable and higher quality mental health care. Other service delivery concepts such as making health care community-accountable or totally integrating medical and mental health care at the local level have much more promise of greater savings and quality than the current closed monopolies employing denial, rationing and general suppression of

mental health services. A no-holds-barred discussion of alternative health delivery models is overdue but that is best left for another day and perhaps a larger public stage.

What can be done now without waiting for ambitious national overhauls of health care delivery is to require HMOs to stop shortchanging their subscribers by denying access to licensed mental health care providers who may well be the most affordable as well as most qualified providers in their area.

Thank you for your consideration of the foregoing. I would be pleased to provide testimony on some future date or to otherwise participate in any working group to help clarify issues and options related to HB 470.

Respectfully submitted,

John P. Brown, Jr., Ph.D.



CIGNA Behavioral Health

October 2, 2000

John Brown Jr., Ph.D
PO Box 642
Newport, NH 03773

330 Whitney Avenue
Suite 400
Holyoke, MA 01040
Telephone 413.493.6000
Facsimile 413.493.6010
Toll Free 1.800.715.0791

Dear Dr. Brown:

Thank you for your interest in participating in the mental health/substance abuse provider network for Cigna Behavioral Health, Inc.

Cigna Behavioral Health develops specialized provider networks for our clients based on demographics of the area, number of participants, Cigna Behavioral Health selection and credentialing guidelines, and specialties required.

After review of your letter of interest and/or resume, we do not require your services at this time due to the following reason(s):

__X__ Cigna Behavioral Health has existing mental health/substance abuse services within proximity of your practice location.

____ The size of the client membership in your geographic location does not support network expansion at this time.

____ The mental health/substance abuse services described in your letter of interest are not covered under benefit plans served by Cigna Behavioral Health, Inc.

____ Your mental health/substance abuse licensure does not meet our requirements. Cigna Behavioral Health network providers must be licensed to practice independently.

____ Your malpractice insurance coverage is below the coverage limits required for Cigna Behavioral Health network providers.

____ Psychiatrists must be board certified to be considered for acceptance into the Cigna Behavioral Health network.

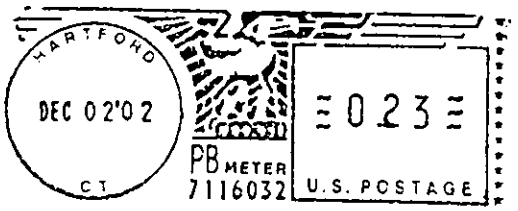
Please note that our network is reviewed periodically and changes may be made from time to time. Be assured that information regarding your practice has been incorporated into our database for future consideration. Further submissions are not necessary.

Thank you for your interest in Cigna Behavioral Health.

Sincerely,

Anita R. Soutier
Professional Relations Representative
Cigna Behavioral Health, Inc.
New England Operating Unit

CIGNA Behavioral Health
900 Cottage Grove Road, S317
Hartford, CT 06152-2317



JOHN P BROWN PHD
PO BOX 642
NEWPORT NH 03773

08

Thank you for your interest in the CIGNA Behavioral Health (CBH) provider network. Although CBH's network is always open to new providers, we develop specialized networks for our participants. At present, network needs are based on multiple criteria, including: 1) the demographics & number of current CBH participants in your area; 2) potential new business growth, and 3) our contract and credentialing requirements.

After a thorough needs assessment, including a review of your credentials and resume, we are unable to proceed with the process for the following reason(s):

____ Your current license does not meet our minimum requirements. CBH network providers must be licensed to practice independently.

____ Your malpractice insurance coverage is below the coverage limits required for CBH network providers.

✓ CBH currently maintains a sufficient number of providers with your discipline and specialties in your specific geographic area.

We will keep your information on file for one year. Should our needs change, we would be glad to contact you regarding your continued interest in our network. Thank you again for your interest in CIGNA Behavioral Health.

Subj: **As Requested: DME maximum - Anthem information**
Date: 02/21/2003 3:39:44 PM Eastern Standard Time
From: Yvonne.Nanasi@Anthem.com
To: l04george@aol.com
Sent from the Internet (Details)

Representative Liebl,
Per your request below is the listing of Anthem BCBS standard DME per member, per calendar year maximum coverage amounts:

BlueChoice local (both 2-tier and 3-tier) is $3500
Matthew Thornton Blue is $3500
HMO Blue New England is $3000
BlueChoice New England is $5000
Preferred Blue (PPO) is $3500

They all carry an additional $350 per member per calendar year for a temporary scalp hair prosthesis.

Our nonstandard groups can change those maximums; most of them either raise the maximum or make the benefit unlimited. But we do have several groups who have set the maximum less than the standard. (these are self-funded groups).

Should you have any questions, I would be happy to collect further information.

~~~~~~

Yvonne Nanasi
NH Director of Government Relations
603/695-7354 (office), 603/695-7992 (fax)
3000 Goffs Falls Rd.
Manchester, NH 03111

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U.S. SUPREME COURT AND THE KENTUCKY "ANY WILLING PROVIDER" LAW

The Kentucky Law in Question:

304.17A-110(3). Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.

Kentucky Assn. of Health Plans Inc. et al. v. Janie A. Miller, Commissioner, Kentucky Dept. of Insurance.

After being upheld as not being preempted by ERISA (Employee Retirement Income and Security Act of 1974) by two Kentucky Federal District Courts and the US Circuit Court of Appeals, the Kentucky case was accepted for hearing by the U.S. Supreme Court. The Supreme Court requested an opinion from the U.S. Solicitor General (the attorney for the US) and received an opinion supporting the Kentucky law. The oral arguments were heard on January 15, 2003, with a decision by the Court predicted for some time in June. To date, there has been a split among the Circuit Courts of Appeals on the issue. This decision may resolve that split.

The issue involves whether or not Kentucky's "any willing provider" law, one of the broadest in the country, would be preempted by ERISA, or deemed to constitute the "business of insurance". State laws regulating insurance are exempt from ERISA and therefore enforceable under state law.

A ruling against Kentucky's statute would put about two dozen "any willing provider" laws applicable to various classes of health care providers in jeopardy. However, a favorable ruling upholding Kentucky's law is likely to encourage other states to enact similar laws and could have an impact on the enforceability of other types of nondiscrimination statutes.

The AOA Health Care Legislation Committee has been working with access legislation since the mid-1980s when "freedom of choice" first became an issue. If the Supreme Court rules favorably on the Kentucky law, the Committee is available to work with those states that may seek non-discrimination legislation.

New Hampshire Chiropractic Assoc., Inc.

The Official State Organization Since 1919

TEL: 603-772-5631 FAX: 603-778-1783

House Bill 470, *An Act relative to health insurance providers*
House Commerce Committee
February 5, 2003

Public Testimony of the New Hampshire Chiropractic Association

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The New Hampshire Chiropractic Association supports House Bill 470, *An Act relative to health insurance providers*. This bill would require health insurers to accept into their provider network any provider who is in good standing with the appropriate licensing authority. The Association believes that this is a very important step in opening the health care market to more competition, consumer choice, and quality of care.

The question at hand in HB 470 is whether the adverse effects of allowing insurers to limit consumers' ability to choose qualified, competent health care providers is a sensible public policy. We believe that that it is not, and that this legislation will improve health care for New Hampshire's citizens.

New Hampshire's managed care structure clearly has room for improvement. When managed care was in its infancy, the concept of closed networks might have seemed to be an attractive tool. However, it has failed to improve the quality of care, and demonstrated no measurable cost containment in the market, as network providers are likely shifting the punitive effects of managed care reimbursement to other consumers. Today in New Hampshire, the true ability of managed care to keep provider payments low is found in the fact that there are only two major health carriers. If providers are not willing to take the reimbursement rates

offered by the "Coke" and "Pepsi" of NH's health insurance marketplace, they can't easily find alternative relationships. The theory of closed networks leading to cost containment has no real value in today's health insurance environment. We are unconvinced that in a marketplace with closed networks and limited competition there are any true benefits, and the adverse effects on consumer choice and quality of care greatly outweigh any perceived value in the system.

The Association is concerned with the effect which closed provider networks have on consumers being able to choose a provider that is best situated for them, and instead inserts into that very personal decision an insurance company as the decision maker. The chiropractic profession is particularly sensitive to this issue. As this Committee may recall, in 2000 the Legislature enacted SB 147, which eliminated the medical gatekeeper for chiropractic care. At that time, the Legislature acted to ensure that those consumers who had purchased chiropractic benefits from their insurance company would be free to choose chiropractic care, without a medical doctor acting as a gatekeeper. The successful theory behind that legislation was that consumers should be empowered to make their own determination about their care giver. The same underlying policy is at issue in this legislation. Limiting the pool of care givers is restricting a patient's ability to find the right care giver for them.

Of particular concern to the Chiropractic Association is the effect closed networks have on new providers who arrive in New Hampshire, but find that despite their competency and quality of care they are able to offer, they are unable to gain acceptance into the limited managed care networks that dominate the health insurance market in our state. In effect, that lack of a thriving and competitive market for insurance carriers, combined with closed networks, creates an inequitable situation for those who seek to open practices and attract patients.

The Association also believes this legislation will help ensure that meaningful improvements are made in the quality of care in New Hampshire as a consequence of consumers, and not insurers, determining which providers succeed. By eliminating providers, insurers are limiting the ability of the health care marketplace to reward excellence. Consumers are able to judge success and limiting options eliminates the marketplaces ability to drive quality. A bureaucratic quality assurance program operated by distant insurance companies is no substitute for the proven success of consumers in the market place.

The central question that the committee will need to address regarding HB 470 is who should determine which providers can and should care for the state's citizens, consumers or insurers.

While we expect that much of today's testimony, and the Committee's consideration of this legislation, will focus on Section I, the Association is also very supportive of section II of the bill that would require a more equitable and professional treatment of the termination of providers in managed care networks. While the section would not eliminate an insurer's ability to terminate a provider relationship, it would ensure it is done with cause and with some level of due process. Again, we would urge the committee to review this section of the bill in light of the lack of a truly competitive market place in New Hampshire. We believe that the effects of provider termination on consumers can be very disruptive to patients' care and in establishing and maintaining a relationship with their provider. An arbitrary determination by an insurer, with no ability to seek appeal or ensure due process is an unattractive public policy at best, and quite harmful to the doctor – patient relationship in practice.

Harvard Pilgrim
HealthCare

February 5, 2003

The Honorable John B. Hunt
Chair, House Commerce Committee
State House
Concord, NH 03301

Re: House Bill 470

Dear Representative Hunt:

I am writing to express Harvard Pilgrim's opposition to House Bill 470 – An Act Relative to Health Insurance Providers. House Bill 470 would require health plans to accept any licensed provider into their networks and would allow providers to terminate their health plan contracts at any time for any reason.

Harvard Pilgrim seeks to maintain contractual relationships with physicians and other health care providers that provide fair reimbursement for services, encourage the timely provision of high quality care and allow coverage to be offered at premium rates that customers can afford. Changing the rules that apply to contract negotiations would make it impossible for us to achieve these goals, resulting in higher costs and lower quality of care.

Requiring health plans to accept any licensed provider into their networks will eliminate any incentive that providers have to negotiate in good faith with health plans, allowing providers to demand higher reimbursements which, in turn, will result in higher premiums. It would also override our credentialing standards. We would no longer be able to take into consideration factors such as a provider's malpractice history and member complaints. This would have a negative impact on the quality of care our members receive. Allowing providers to terminate their contracts at any time and for any reason essentially gives them the right to re-open contract negotiations at any time and demand additional compensation, leaving consumers vulnerable to disruptions in care.

Harvard Pilgrim urges you to find House Bill 470 inexpedient to legislate. Thank you for your consideration.

Sincerely,

Lora M. Pellegrini
Manager, Government Relations

Harvard Pilgrim Health Care, Inc.
93 Worcester Street
Wellesley, Massachusetts 02481

Sponsor: Rep. Michael Gilman 444-1512 email: Mgilman@ncia.net
Spokesperson: Dr. Deborah Warner, Littleton (social security number withheld).

I. Health Insurance Bills HB 470, HB 471, HB 472

Health Insurance reform has much public support. Yet reasonable practices must prevail. Unfortunately, in the current market, there is an imbalance, with insurance companies dictating procedures as they choose, demanding more labor intensive and costly adherence requirements to the silenced providers while also cutting back on reimbursements. In the end, the consumer suffers with no voice, less choice in health care, and higher costs. These bills address these issues in a fair and balanced fashion, providing a voice to all stakeholders in the process and providing reasonable methods for assessing system wide problems and methods for fair feedback.

II. "Any Willing Provider"

HB 470 would require that insurance companies allow open enrollment of doctors, which would improve access to medical care, and would allow doctors to be better advocates for their patients without fear of reprisals by the insurance carrier.

A. Increased supply of doctors
    1. Expand consumer choice
        a) More doctors in insurance plan
        b) More doctors will move here due to open market
    2. Lower costs through competition
    3. Competition stimulates quality delivery

B. Improved access to care
    1. More readily available appointments
    2. More use of preventive care
    3. Rural areas with adequate coverage and improved access
    4. Preventive care improving health and reducing more expensive medical interventions later

C. Doctors free to practice and advocate for proper patient care
    1. Without threat of being terminated from panels and jeopardizing economic survival
    2. Able to order appropriate tests for diagnosis and recommend appropriate treatment
        a) Saving lives - & not finding out 2 weeks before death that someone has colon cancer

D. Restraint of Trade
    1. American business methods do not endorse one group imposing unfair restrictions on the practice and business of another group of businesses

III. Privacy Clause

HB 470 deals with insurance company relationships with doctors. It includes a privacy clause to keep the insurance company from disclosing personal private information about doctors to patients. Information such as the doctor's social security number, home address and telephone and such similar information.

A. HB 470 Protects secure access to patient records and prevents breaches, it protects patient confidentiality
B. HB 470 Protects doctors from identity theft, where others might use the doctor's identity for criminal purposes or financial fraud
C. HB 470 Protects doctors from invasion of privacy
    1. I.e., phone & utility records, financial data
    2. Family and children's security
D. HB 470 Protects doctors from stalking by high risk patients

IV. Cost Containment

HB 471 addresses the cost containment practices of the insurance companies and provides reasonable limitations on such practices so that they do not interfere with the conduct of the provider's care.

A. Making insurance review process a reasonable inquiry about patient response to care, not micro-managing a competent doctor's care
B. Spacing of reviews to coincide with average response to treatment for given diagnoses or classes thereof
C. Cost to consumer
    1. Doctors of various specialties spend considerable time writing treatment reports and tracking "authorizations" for care
    2. This is uncompensated time thus it raises the cost of other medical services
D. Privacy Implications
    1. For most patients responding to treatment, very little detail needs to be transmitted to the insurance company.
        Most patients will respond to treatment within the initial coverage unit. Thus for most patients, very little personal medical information would be shared with the insurance carrier because detailed treatment care plans would not be necessary.
    2. Under this legislation, less than half of patients receiving monitored services would be subject to detailed review.
        Although all insured patients sign a waiver to allow the transfer of information, it is best to keep the scope and frequency of transmitted information at a minimum, for the benefit of privacy. The utility of sharing information is only pertinent for those whose response to treatment is sluggish or using extra financial resources.

V. Insurance Advisory Board for the Insurance Commissioner

HB 471 would create an advisory board to the insurance Commissioner, finally giving a voice to consumers and providers to discuss pressing issues with insurance providers who have long had the upper hand in the arena, and to bring forward issues of practice to the Commissioner for action. The advisory board created by HB 471 would also report back annually to the legislature concerning the state of insurance issues and recommend further action as needed.

A. Nearly every other major issue and regulatory agency has an advisory board.
    1. These collaborative boards are constructed to represent the "stakeholders" affected by a particular regulation or issue. Thus most

boards are comprised of representatives of parties that regulate, those who are regulated and consumers

2. In NH, there are many more than 50 advisory and regulatory boards for various issues from electrical supply, to beauticians and barbers, to rehabilitative services, and college and university systems, & you name it.

3. This advisory process is done because it is considered a good way to discuss issues and balance the perspectives and needs of these parties.

    a) The focus is to deal with the practical application of rules, regulations, and practices, providing informed feedback and to generate reasonable solutions.

    b) It is considered important to have balance of input by stakeholders so that one or another faction does not have undue influence on the process of the system.

4. Health care is one of the major pressing issues in America today.

    a) In ratings polls, it is in top three election issues, and moves into first place at some times.

    b) Such an important issue should not leave the stakeholders without a voice.

5. Health care is changing rapidly and needs a responsive process to deal with its regulation, with rapid feedback and depth of input.

    a) Medical practices have changed dramatically in last 20, 10 and even 5 years.

        (1) Economics: Doctors have had to hire new divisions of staff to deal with insurance company demands on time and tracking

        (2) Ethics: End of life issues have changed greatly with complicated care and economic impact

        (3) Availability: E.g., Some expensive treatments are now affordable such as AIDs medications

    b) Insurance companies have restructured and shifted risks and costs into new areas

        (1) Non-profits have become for-profits

        (2) Companies are limiting procedures

        (3) There are fewer insurance companies based in NH

        (4) Companies are looking for all possible ways to curtail costs and keep premiums low

    c) Consumers must deal with access and quality issues

        (1) Affordable insurance and health care are high priorities

        (2) Access to local doctors who have available appointments is necessary for adequate care

        (3) Faith in doctor's care is essential to trust that all appropriate tests and procedures will be used to deliver quality care

(4) In current system, the consumer is dis-empowered, i.e. see movie John Q, many people found they could relate to this film—as the desperate acts of being alienated from the process

d) All three groups need to work together to bring about successful and practical solutions

(1) Finding NH solutions to address our widely acknowledged "health care crisis"

(2) Empowering consumers and providers and insurers with regulators in balanced input to address regulatory issues in a practical manner

(3) Each of these groups: consumers, providers and insurers-- invited to this board is missioned to support the well being of each other. Their goal shall be to advise the Commissioner with suggestions of local NH solutions at reasonable cost for quality care that is sustainable for providers and insurers and affordable for consumers.

VI. Insurance Terminology

HB 472, would prohibit insurance companies from using misleading terminology that confuses people about their actual role in medicine. Under HB 472, insurance companies would be prohibited from using terms such as "Managed Care," since they do not provide care nor actually manage any care, as care is managed and provided by doctors, nurses and hospitals, but not by insurance companies. Insurance companies issue units of insurance to cover such services, but do NOT provide care nor are they licensed to manage one's medical care.

A. "Care"

1. The term "CARE" in the medical field is widely understood to mean the provision of services to benefit the patient.
2. Insurance companies have co-opted this term in their attempt to insinuate themselves into the decision structure of the doctor's provision of care.
3. The use of the term CARE by insurance companies confuses the public about who is in charge of their care.
   a) The insurance company manages risk not care.
   b) It is the doctor who manages your care.

B. "Authorize"

1. In truth, it is only the patient who authorizes the doctor to deliver care or treatment.
2. The insurance company in truth does not authorize treatment, but issues coverage units.
   a) The insurance companies currently call their coverage units "treatment authorizations."
   b) In truth, once the patient has consented to the doctor's care, it is the doctor who then authorizes further treatments and tests under their license to practice that specialty on behalf of patients who have given their consent for care

C. What do Insurance companies manage then?

1. Risk is not managed individually.
   Insurance companies manage risk in their actuarial tables and setting of insurance rates. Their issuance of insurance units for covered services is unrelated to their managing of risk, which is done over the entire population and on an annual basis prior to contract renewals.
2. Insurance companies review utilization rates and compare practices to population averages.
   There is no way for a mathematical formula to administer medicine, nor should it dictate a particular patient's care.
3. How can they reasonably contain costs?
   a) They may place limitations on particular services by contract.
   b) They may investigate fraud.
   c) They could make unobtrusive reviews of patient progress for slow-responding or intractable cases, in streamlined peer review formats, by other licensed practitioners who can understand individual patient response.

VII. Conclusion

Being heard is important to all people. The words we use to define ourselves and our actions have great impact on how we react, what we see as our duty and what we will do to remedy problems. Certain words are relevant to the field of medicine. Health Care is a responsibility for individually licensed practitioners subject to professional standards. Insurance's cost/risk containment is a serious responsibility to shareholders and society. Honesty in representation is essential to solve these issues in truth. Access to impacting the system -- by each affected party – the consumer, the provider, the insurer, -- is the only method that will result in balance.

These bills address a system that is out of balance to set it back right again. Speaking the truth, giving each party a voice, respecting privacy, honoring America's open market, working together on systemic problems -- will set our course for a better New Hampshire, a New Hampshire that will take the lead in bringing America ahead to a fair and affordable health care and a healthy economy that other states will emulate.

NEW HAMPSHIRE PSYCHOLOGICAL ASSOCIATION, INC.

Affiliated with the American Psychological Association

P.O.Box 1205, Concord, New Hampshire 03302-1205

Phone/Fax: (603) 225-9925 E-Mail: office@nhpaonline.org Web site: nhpaonline.org

February 5, 2003

Dear Chairman Hunt and Honorable Members of the House Commerce Committee:

On behalf of the NH Psychological Association, I urge you to support House Bills, 470 and 471. These bills would make meaningful changes to the insurance system in New Hampshire which would be of great benefit to consumers.

House Bill 470 would allow any licensed provider to become a part of a managed care panel. This system would allow consumers to select the health care provider of their choice. With mental health services, this is a particularly important option, since optimal care can occur when the client and the therapist have a good rapport.

House Bill 471 would enact a review board which would serve to advise the insurance commissioner about insurance matters. Again, this is a great idea for the system. This review board would enable all parties involved with the system to provide important feedback. It could serve to work problems out earlier and more efficiently thereby avoiding the necessity of legislation. Psychologists would welcome this opportunity to work collaboratively with the insurers.

Psychologists work with the insurance system regularly and would be happy to provide you with more information during this process. Please do not hesitate to contact me at the above number if you have questions.

Sincerely,

Karen Jennings

Karen Jennings, Ph.D.
President

Anthem Blue Cross and Blue Shield
3000 Goffs Falls Road
Manchester, NH 03111-0001
Tel 603 695-7000
www.anthem.com

Anthem.

House Commerce Committee
February 4, 2003

RE: HB 470 – Any Willing Provider Network Requirement and Provider Information Disclosure Requirement

Submitted By: Yvonne Nanasi, Director of Government Relations

Anthem Blue Cross and Blue Shield (Anthem BCBS) is opposed to HB 470. The bill will increase the cost of health insurance, stifle the availability of innovative cost containment products, create significant medical provider credentialing and claims processing problems as well as hinder fraud investigation.

Any Willing Provider Requirement

The bill's "any willing provider" (AWP) provisions would require insurers to contract with any health care provider who is in good standing with their licensing board without regard to quality of care or cost efficiency. It would undermine the ability of managed care health plans to select high quality, efficient providers. The ability to selectively contract with efficient providers is integral to the ability of health plans to control costs and monitor quality on behalf of consumers. Consumers enrolled in managed care plans pay lower premiums than they would under a traditional fee-for-service plans because of the lower costs that manage care plans have with a network of providers.

HB 470 would raise administrative costs by forcing health plans to credential a larger number of providers than would normally be admitted saddling plans with more providers whose practice patterns need to be monitored. Anthem BCBS estimates that in the mental health area alone about 1000 more practitioners would be required to be credentialed. The additional cost for only mental health care practitioners would be about $75,000 (average cost $75 per practitioner). Further cost increases would be incurred for pharmacies, chiropractors, podiatrists, nurse practitioners, lay-midwives, etc.

There are further cost increases associated with AWP requirements. A 1992 Wyatt Company study found that a typical managed care plan's claims costs increased between 8.8% and 14.4% when forced to admit any willing provider into their network.

Confidentiality of Provider's Personal Information

The provisions of the bill that prohibit "divulging" a provider's personal information will create significant problems in the credentialing, payment of claims and obstruct fraud investigations.

USA

An independent licensee of the Blue Cross and Blue Shield Association.
Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc.
® Registered marks of the Blue Cross and Blue Shield Association.

When ensuring that a provider is properly credentialed to provide services to our members, Anthem BCBS requires the provider's social security number, date of birth and home address as well as VISA number if not a US citizen. Health plans need to "divulge" this information to state licensing boards and the National Practitioners Data Bank to verify that providers have the expertise needed and a license in good standing.

Over the past three years, health plans, nationwide, are standardizing their credentialing materials to accommodate provider's need for less paper work while ensuring proper credentialing procedures. A provider's social security number, date of birth and home address provide important verification information to ensure that our members are getting services from properly credentialed providers who have a history of providing appropriate medical care.

Moreover, the Federal Employees Health Benefit Plan (FEP) requires that the provider's social security number be used for payment of claims. Anthem BCBS administers FEP in NH for services to FEP members. We cannot submit claims for payment to providers absent a social security number for processing unless the provider has applied to the IRS for a specially assigned tax identification number (TIN). Many medical providers in NH use their social security number rather than applying for a TIN.

Many NH medical providers in rural regions of the state, particularly those who are not physicians, use their home address as the billing address as it is the same address where they provide services. The NH external grievance process requires that health plans provide a copy of the members file during a review. The home address information for these providers will be contained in the file materials for the member, their legal representative, and the external grievance review entity chosen by the NH Insurance Department to view.

This restrictive provision will cause Anthem BCBS, our members, subscribers and providers a number of problems that will be costly to avoid.

Summary

HB 472 is regressive legislation that will stifle competition and development of new insurance products.

We certainly appreciate your attention to our concerns and would be willing to assist in providing further information.

State of New Hampshire

HOUSE OF REPRESENTATIVES

CONCORD

RECEIVED
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By

MEMORANDUM

DATE: October 30, 2003

TO: Honorable Craig Benson, Governor
Honorable Gene G. Chandler, Speaker of the House
Honorable Thomas R. Eaton, President of the Senate
Honorable Karen O. Wadsworth, House Clerk
Honorable Steven J. Winter, Senate Clerk
Michael York, State Librarian

FROM: Rep. Paul D. Spiess, Chairman
9 Roberts Road, Amherst NH 03031-2608
(603) 673-6770

SUBJECT: Final Report on HB 470, relative to the contracting process between managed care insurers and health care providers

Pursuant to Chapter 284:4, Laws of 2003, enclosed please find the Final Report of the committee charged with studying the contracting process between managed care insurers and health care providers.

If you have any questions or comments regarding this report, please do not hesitate to contact me.

PDS:co

cc: Study Committee Members
Pam Smarling, Committee Researcher

FINAL REPORT

RE: HB 470 (Chapter 284:4, Laws of 2003) relative to the contracting process between managed care insurers and health care providers

This committee was established as a result of passage of HB 470 relative to health insurance providers. Among other provisions, the bill created a committee to "study the contracting process between managed care insurers and health care providers in the state".

The committee was organized to be composed of three members from the House of Representatives and three members of the Senate. Selected to represent the House were:

Rep. Stephen DeStefano
Rep. George Liebl
Rep. Paul Spiess.

Representatives of the Senate were:

Sen. Iris Estabrook
Sen. Robert Flanders
Sen. Andre Martel.

The committee held an organizational meeting on Wednesday, October 1, 2003. At that time, Rep. Spiess was selected to chair the committee. The members discussed various ways to proceed with the task, and decided upon three primary areas of interest to be examined: cost shifting from Medicaid/Medicare insurers to private pay insurance plans; the concept of "any willing provider; and the contracting process between managed care insurers and health care providers. It was determined that a separate meeting for each topic was appropriate.

Cost Shifting:

A meeting was held on Thursday, October 9, 2003 to examine the impact and consequences of the concept of shifting costs between governmental insurance programs (i.e., Medicaid and Medicare) and private insurance programs. Of significant help to the committee was a report prepared by the New Hampshire Center for Public Policy entitled *"Cost-Shifting in New Hampshire Hospitals"*, presented by Douglas Hall (see *Attachment "A"*). This issue is deemed relevant by the committee because the impact of cost shifting between government and private pay plans is causing financial stress and economic tension between insurers and providers. The Center's report provides an in-depth look at the

concept of cost shifting and measures the impact upon private plan insurers and hospital providers.

Subsequent testimony indicated that cost shifting has a greater or lesser impact upon hospitals based upon their size, the mix of their patients, source of insurance payments, and their geographic location. It was evident from a chart presented by the New Hampshire Hospital Association and supported by testimony that smaller hospitals, located in rural and semi-rural areas which serve an older or more indigent customer base, are most severely impacted by cost shifting.

The committee also received three articles from the publication, *"Health Affairs"*, which provided further insight into the causes and effects of the problem.

Any Willing Provider:

The committee held a hearing on Wednesday, October 15, 2003, to hear testimony concerning the concept of "any willing provider". One of the driving forces behind the concept of managed care plans was the desire to drive down the cost of health care through negotiated agreements between insurers and providers. Insurers wanted to be able to choose which providers would be in the plan and to negotiate reimbursement agreements based upon a number of factors. One of the practical results of this process is that not all providers are accepted into the various plans. This can result in patients being required to change providers (i.e., physicians) or receive services at less accessible locations. The plans also tend to consolidate services to a select group of providers, weakening the economic viability of providers outside the plan.

The committee heard testimony from representatives of the insurers that opening the plans to any providers willing to accept the terms and conditions of the plan could increase administrative costs up to 15%. It would also weaken the value of the negotiated contract to providers within the plan. Providers excluded from the plans felt the practice was discriminatory, and could possibly be an anti-trust violation by artificially restricting the supply of providers.

The committee recognized that the health insurance market is highly consolidated in New Hampshire, with CIGNA and Anthem representing 80% of the premiums received. It was felt that a further examination of the monopoly/anti-trust issues might be necessary to assure a competitive provider market. The following materials were provided to the committee:

- The Managed Care Handbook (pp. 1334-1335)
- The Challenge of Managed Care Regulation
- Kentucky's "Any Willing Provider" Law and ERISA
- Council of State Governments: Any Willing Provider Laws: Managed Care or Restraint of Choice?

Contracting Process:

The committee held a hearing on Thursday, October 23, 2003 to hear testimony relative to the process that insurers and providers utilize to negotiate service contracts. The committee heard a description of the contracting process from the perspective of the insurers (see written testimony of Doug Wenners, in file) and from the perspective of hospitals (see written testimony of Christopher Gallagher and Walter Maroney, in file).

The recent contract negotiation between Anthem and Lakes Region Hospital was used as an example of how the process can reach impasse. The committee was particularly concerned about the impact upon consumers if insurers and providers cannot reach agreement. The Insurance Department gave testimony concerning its "unofficial" capacity to mediate disputes. At present, there is no statutory role for the State in the contracting process.

The committee believes that it may be in the public interest to give the State a statutory capacity to act as a mediator if an impasse occurs.

There was considerable discussion about whether there is equal bargaining power between insurers and hospitals. The committee recognizes that insurance premiums/policies are highly concentrated (80%) within two insurance companies – Anthem and CIGNA. This creates a defecto "duopoly" which makes it difficult for providers to obtain competitive proposals. Conversely, hospitals often tend to virtually monopolize local geographic areas which gives them considerable bargaining power when insurers must provide adequate access to services. It is also recognized that larger, full-service hospitals located in densely populated areas possess more resources and bargaining leverage than smaller/rural hospitals. The committee raised the question of whether small hospitals' bargaining positions would be enhanced if they were allowed to bargain collectively.

Time did not permit the committee to hear all the relevant testimony. The subject was carried over to the next meeting.

Conclusion, Summary and Recommendation:

The committee held its final meeting on Tuesday, October 28, 2003. At that time, testimony resumed on the contracting process.

Upon completion of the testimony and discussion, the committee felt that significant progress had been made in understanding the contracting process

and the many forces and issues that affect the parties to the process. It was agreed that future legislation may be necessary to:

1. Correct economic imbalances in the payment system.

2. Assure that monopolistic practices do not emerge to distort the contracting process.

3. Assure access to necessary information to monitor predatory practices.

4. Provide for a statutory role for the State in the negotiating process.

The committee felt that more time and work was needed before bringing forward recommendations for specific action. A motion was made by Sen. Flanders and seconded by Sen. Estabrook to request a continuation of the study committee through November 1, 2004. The motion was approved on a 5-0 vote.

The committee authorized Rep. Spiess to compose a report and request an appropriate extension.

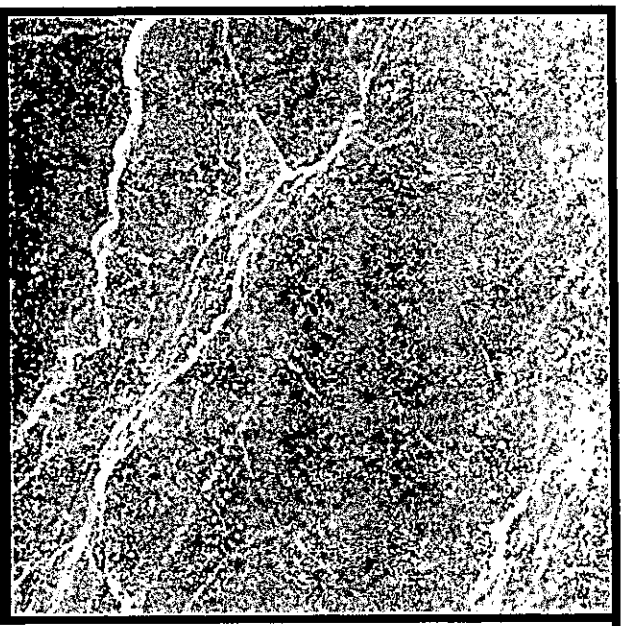
Respectfully submitted,

Rep. Paul D. Spiess, Chairman
On Behalf of the Committee

PDS:co

Attachment: *Attachment "A"*, Copy of "Cost-Shifting in New Hampshire Hospitals"

New Hampshire Center for
PUBLIC POLICY Studies



www.nhpolicy.org

Cost-Shifting in New Hampshire Hospitals

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October 2003

Executive Summary

New Hampshire's hospitals generally lose money every time they care for an elderly person whose charges are paid by Medicare. The same is true for low-income patients whose charges are paid by Medicaid. Those public programs don't reimburse hospitals enough for the hospitals to cover their costs, let alone generate enough income to invest in new equipment or other services. Those hospitals with disproportionately high percentages of elderly or poor patients are generally in worse financial condition than those that treat more patients with conventional health insurance. That's because those patients—and the companies that employ them and provide their insurance—are making up much of the revenue the hospitals need to stay in business.

The Center estimates that in 2001—the last year for which all data are available—New Hampshire's employers and individuals with private health insurance paid what amounts to a hidden tax of 17 percent on that portion of their insurance bills that pays for hospital care. That tax helps hospitals offset underpayments elsewhere. Private payers—including health insurance carriers, self-insured businesses, and individuals—paid $197 million to hospitals in excess of what might be considered the real cost of their services.

The total amount of "cost-shifting" in 2001 was even larger, however. Hospitals themselves "contributed" some $39 million in reduced operating margins. In total, the Center estimates, New Hampshire's 26 hospitals shifted $237 million in costs from Medicare, Medicaid, and patients unable to pay.

The extent of cost-shifting has not been apparent to employers, insurance providers, patients, voters and the elected and appointed people who set Medicare and Medicaid reimbursement rates. The lack of easily available public information about hospital charges and payments has weakened the cost signals that could help foster more market competition in health care. More clarity would also help the legislature and Congress make more rational decisions about health care policy and finance. The Center calls on hospitals and insurance carriers to make relevant data public.

1. Introduction: The Business of Hospitals

New Hampshire has 26 acute-care hospitals, two of which are for-profit enterprises. The financial well-being of all of these institutions is important to the communities they serve and to the state as a whole. Whether it is a non-profit organization or is part of a profit-making corporation, each hospital attempts to balance its revenue and its expenditures and still leave a positive net margin. The hospitals' annual reports typically announce how successful their boards and managers have been in this business enterprise.

Those financial reports show operating costs and revenues, and the amount of "charity care" and bad debt absorbed by the hospital. But the reports do not reveal much about the kind of costs each hospital confronts nor about how much it charges various types of patients to cover those costs and generate an operating margin. This paper does that for the first time in New Hampshire. The paper defines "cost-shifting" in hospitals and quantifies its magnitude across

the 26 hospitals combined and in four particular hospitals. Using a series of graphs, the paper displays how cost-shifting is affecting these hospitals and, in turn, the state's health care system.

Understanding cost-shifting will help voters, health-care consumers, and policy makers understand the impact of their decisions. The paper shows, for example, that federally set Medicare reimbursement rates are too low, in New Hampshire at least, and are thus raising costs to those employers providing health insurance to their workforce. Raising reimbursement rates—and the payroll taxes that fund Medicare—would spread those costs among a much broader workforce. This paper raises policy choices that it cannot yet answer; it is an introduction to the topic, not the last word.

2. Cost-Shifting Defined

Cost-shifting is in part a function of a hospital's "patient mix" and "funding mix."

Most hospital care is paid for by commercial health insurance, by the federal Medicare program for seniors, the state Medicaid program for low-income and disabled individuals, and directly by patients who have received care. Hospitals also provide charity care for which they receive no payment. A hospital may be paid very different amounts for the same service by different payers. When the payment received is inadequate to cover the actual costs, hospitals must find the financial support for services from some other source or they will soon become financially impaired. A common term for this is "cost-shifting." One definition of cost-shifting is, "the allocation of unpaid costs of care delivered to one patient population through above-cost revenue collected from other patient populations."[1] Other terms that are used to describe the same facts are "price shifting," "margin shifting," "price discrimination," and "reimbursement shifting." This cost-shifting in health care is often described qualitatively, but rarely quantified.[2]

Hospital "patient mix" refers to the relative proportion of patients whose medical care is paid for by different payer types. Some are Medicare patients, some are self-pay, some have their services paid for by third-party insurers, some by Medicaid. The patient mix differs by type of service. Figures 1 and 2 display the mix of patient types served in aggregate by New Hampshire's 26 acute care hospitals in 2001.[3]

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[1] "Cost Shifting: An Integral Aspect of U.S. Health Care Finance," Al Dobson, The Lewin Group, November 13, 2002, at an invitational meeting "When Public Payment Declines Does Cost-Shifting Occur? Hospital and Physician Responses," sponsored by The Robert Wood Johnson Foundation and conducted by AcademyHealth in Washington, DC, November 13, 2002.

[2] Participants at the meeting noted in footnote 1 included foundation managers, consulting firms, health finance experts from academia, health care policy analysts, and government officials. None was able to cite any quantitative studies of cost-shifting.

[3] Patients counts are for the calendar year 2001. Source: Foundation for Healthy Communities, derived from Uniform Hospital Discharge Data Set.

Figure 1

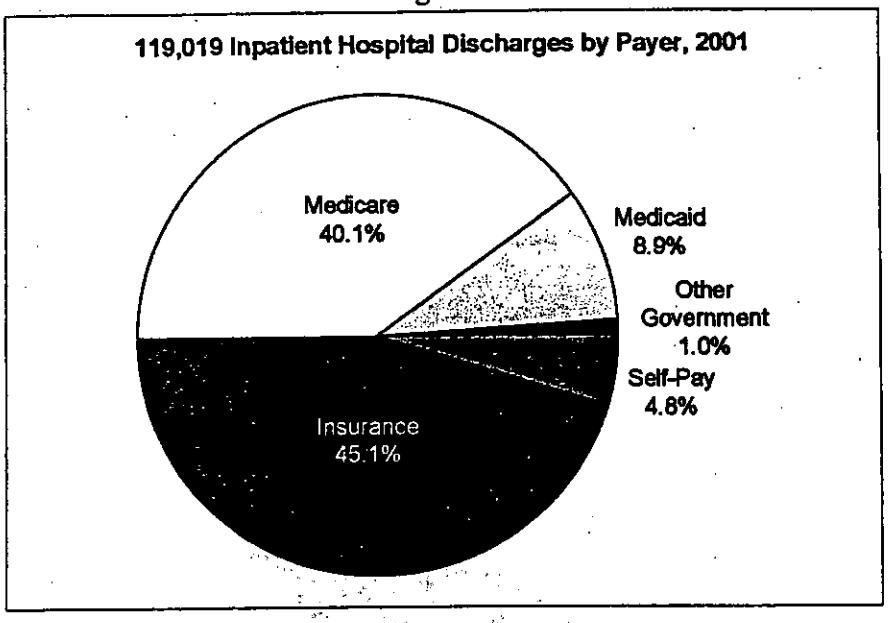
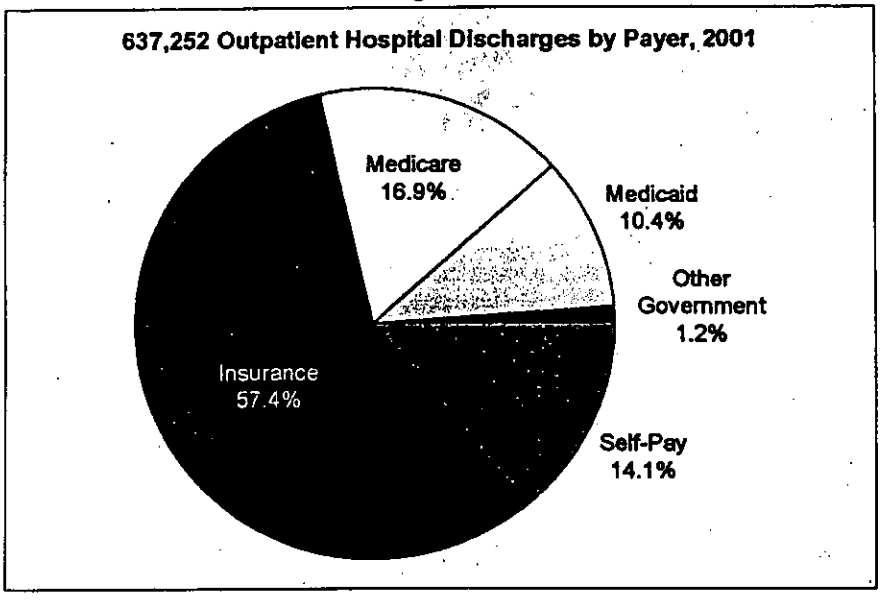


Figure 2

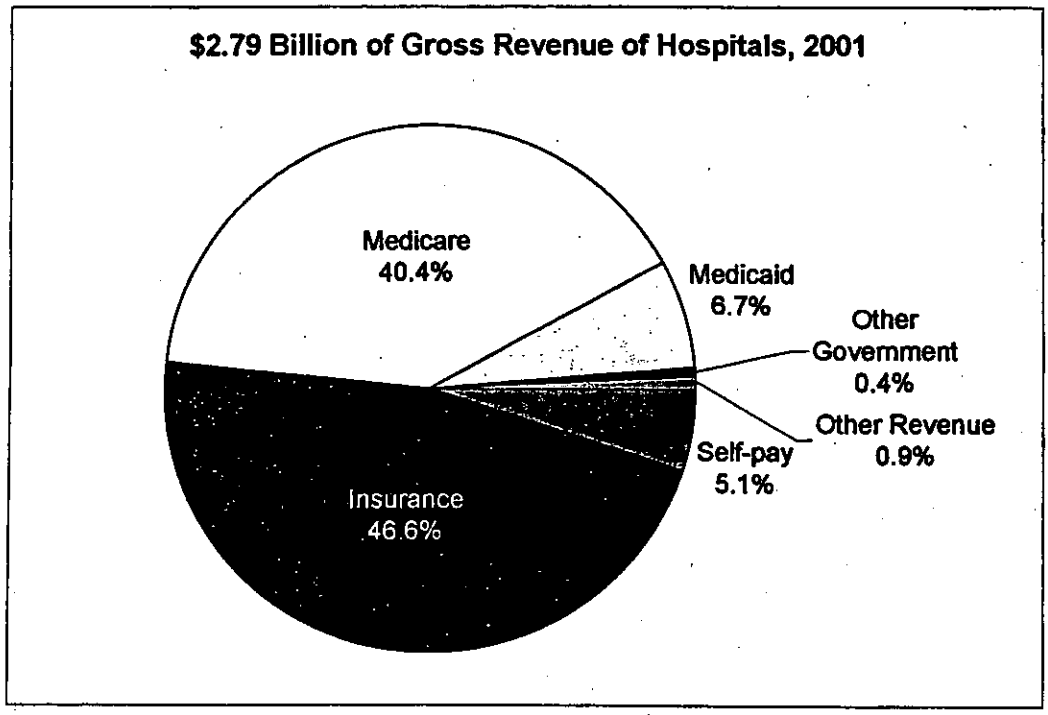


Almost exactly 50 percent of the 119,019 patients who received inpatient services had their services paid for by government programs. Among patients who received outpatient care (not admitted for overnight stay), however, only 28 percent had their services paid for by government programs.

Medicare was the responsible payer for 40 percent of the inpatient discharges but only 17 percent of the ambulatory discharges. Patients who were responsible to pay for the hospital's services out of their own pocket were slightly less than 5 percent of inpatients, but nearly triple that percentage among outpatients.

Based on rates they establish internally, hospitals bill for each service they provide. In 2001 the 26 acute care hospitals billed a total of $2,789,731,668 for the services they provided.[4] Figure 3 displays the percentage of those charges that were attributable to different payer types.

Figure 3



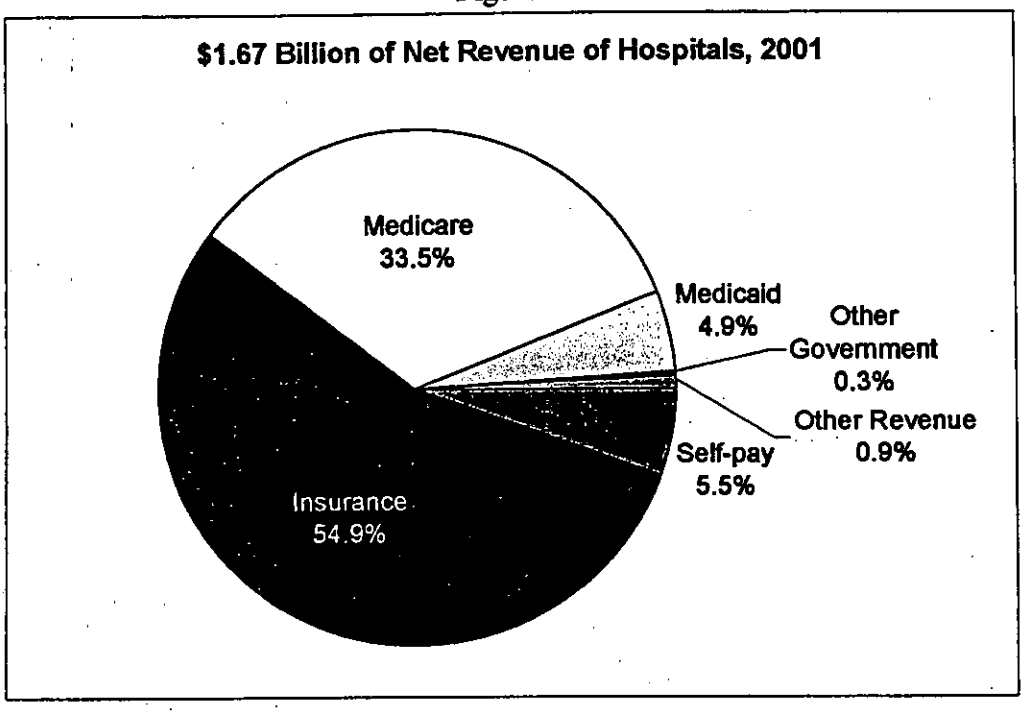
Patients whose bills were paid by private insurance companies accounted for about 47 percent of all charges. Medicare patients accounted for about 40 percent. The pie chart shows that there is nearly an even split between billings to government programs (Medicare, Medicaid, and other government) and to private sector payers (insurance and self-pay). When one considers that some of the patients whose charges are billed to their insurance are public sector employees (teachers, state and local government employees), it is clear that more than half of the gross charges are ultimately public responsibility.

Gross charges, however, considerably exceed the amount hospitals actually receive as revenue. Commercial insurers have negotiated discounts to the standard billed rates; Medicare and Medicaid establish their own payment scales; some individuals do not pay their bill in full, seeking charity care or defaulting on payment.

The revenue actually received for patient care in 2001 was $1,669,813,570. This was only 60 percent of the gross charges. Figure 4 displays the percentage of realized revenue from different payers.

[4] Revenue data from American Hospital Association survey spreadsheet tables prepared by the NH Hospital Association. This is an aggregate of reported 2001 fiscal year data; all hospitals do not use the same fiscal year.

Figure 4



Public programs only paid 39 percent of the revenue the hospitals actually received although they constituted about 47 percent of the gross charges. Insurance companies, however, paid 55 percent of the revenue while their patients represented only 47 percent of the gross charges.

3. Charges Are Not Costs

As noted above, gross charges for all patient services in the 26 hospitals in 2001 were $2,789,731,668. Actual operating expenses for 2001 were $1,723,705,402. If all gross charges had been paid in full, the hospitals in aggregate would have had a markup ratio of 62 percent and net operating income of over $1 billion.

The hospitals did not intend or expect to generate such a huge net income. Gross charges had been set high so that "discounts" could be negotiated with major payers and still result in a modest income.

In considering the issue of hospital cost-shifting, it is important not to assume that anyone underpaying gross charges is failing to pay a "fair share" of costs. Charges are not costs.

4. Marginal Costs and Average Costs

The marginal cost of providing a single additional service in a hospital may be small. At the unit of service level, nearly all costs, including staffing, equipment, maintenance, contracted services, and debt service would have to be considered fixed costs. Certain supplies and medications might be the only marginal costs actually incurred in treating one additional injury in an emergency room, for example.

While some economists have argued theoretically that cost-shifting occurs only when payment for services is below marginal costs, this is not a practical way of viewing hospital finance (or other health system finance). If all payers were expected to pay only for their marginal costs, that would leave no source of revenue to pay the hospitals' fixed costs.

We take the position that cost-shifting occurs whenever certain payers pay less than average cost while others pay more than average cost for any service.

5. The Cost-Plus Basis

If hospital charges were set so that gross revenue exactly equaled expenses, hospitals would not be able to generate a net income and increase their fund balances. Under such conditions, the state's two for-profit hospitals would not generate any profit. Even the 24 non-profit hospitals need to generate a small positive income in order to provide funds for investment in new equipment or hold as reserves against the possibility of unexpected losses in subsequent years. A net operating margin of 62 percent is implausibly high and a net operating margin of 0 percent is too low.

The aggregate net revenue of all hospitals in 2001 was $70,872,799 on net operating revenue of $1,723,705,402; this was an average margin of 4.1 percent. Table 1 contains the aggregate margin of the acute care hospitals for each year from 1992 to 2002.[5]

Table 1

Year	Net Operating Income	Total Operating Expenses	Operating Margin
1992	$43,410,545	$974,671,211	4.5%
1993	$29,989,583	$1,039,670,165	2.9%
1994	$63,196,739	$1,058,967,177	6.0%
1995	$56,671,474	$1,146,625,066	4.9%
1996	$52,444,145	$1,200,793,556	4.4%
1997	$70,902,929	$1,258,418,306	5.6%
1998	$42,478,391	$1,325,787,093	3.2%
1999	$41,640,425	$1,417,449,304	2.9%
2000	$46,592,048	$1,548,480,634	3.0%
2001	$70,872,799	$1,723,705,402	4.1%
2002	$84,520,774	$1,905,109,946	4.4%

We take the position that an average operating margin of 5 percent would be reasonable to ensure sufficient funds for future investment.[6]

[5] Source: spreadsheets from NH Hospital Association containing data from audited financial statements of the hospitals for these years. These data differ in small ways from the AHA data for the same time periods. The reasons for the differences are not known, but they are small and do not affect the general presentation or conclusions.

[6] A hospital's overall margin will differ from its operating margin. Hospitals may obtain revenue and have expenses unrelated to operations (e.g., interest income and capital gains and losses from investments). These other activities will result in a total margin that is greater than or less than the net operating margin.

Thus if all payers paid for actual costs plus a 5 percent margin, then hospitals would generate a 5 percent net income from patient services at the end of a year.

6. Charity Care, Self-Pay, and Bad Debt

A relatively small number of people are billed directly for their hospital care because they have no private insurance and are not eligible for a public program. Others are insured but must pay directly for certain services up to a deductible amount before their insurance will begin to pay.

Some individuals may not be able to actually pay the charges for their care.

"Charity care" is care that a hospital agrees in advance to provide for free. Based on an application by an individual for assistance, the hospital agrees not to bill for the care. For accounting reasons, because no billing is done, the charges are not included as revenue in a hospital's income statement. Gross charges for charity care that were not billed in 2001 were $45,736,960.[7]

Gross "Self-pay" charges are the billed amounts that hospitals expect patients to pay directly. These amounts are included in gross income. Some patients pay these charges in full. Others, however, never pay the full amount. Like any other business, a hospital must occasionally write-off its bad debts. For accounting purposes, the hospital records a "bad debt" expense equal in value to the billed charges that are being written off. As a result, the gross charges for the services it provided are included in both revenue and expense in the hospital's income statements.

Table 2

Payer	Gross Charges	% of Charges
Insurance	$1,298,801,314	45.8%
Medicare	$1,125,742,085	39.7%
Medicaid	$185,786,720	6.6%
Charity care	$45,736,960	1.6%
Bad debt	$96,243,326	3.4%
Self-pay received	$46,183,348	1.6%
Other government & other	$36,974,875	1.3%
Total	$2,835,468,628	100.0%

Table 2 reports the total of gross charges, including charity care. The rightmost column displays the percent of gross charges attributable to each payer type when the charity care is included. The amount that individuals should have paid directly consists of the three categories: charity care, bad debt, and self-pay received.

2001 operating expense as reported on the hospitals' income statements was $1,723,705,402. However, this amount includes $96,243,326 of bad debt write off. These write-offs must be subtracted from the stated expenses to determine the real cost of services. "Real cost" of services in 2001 was $1,627,462,076.

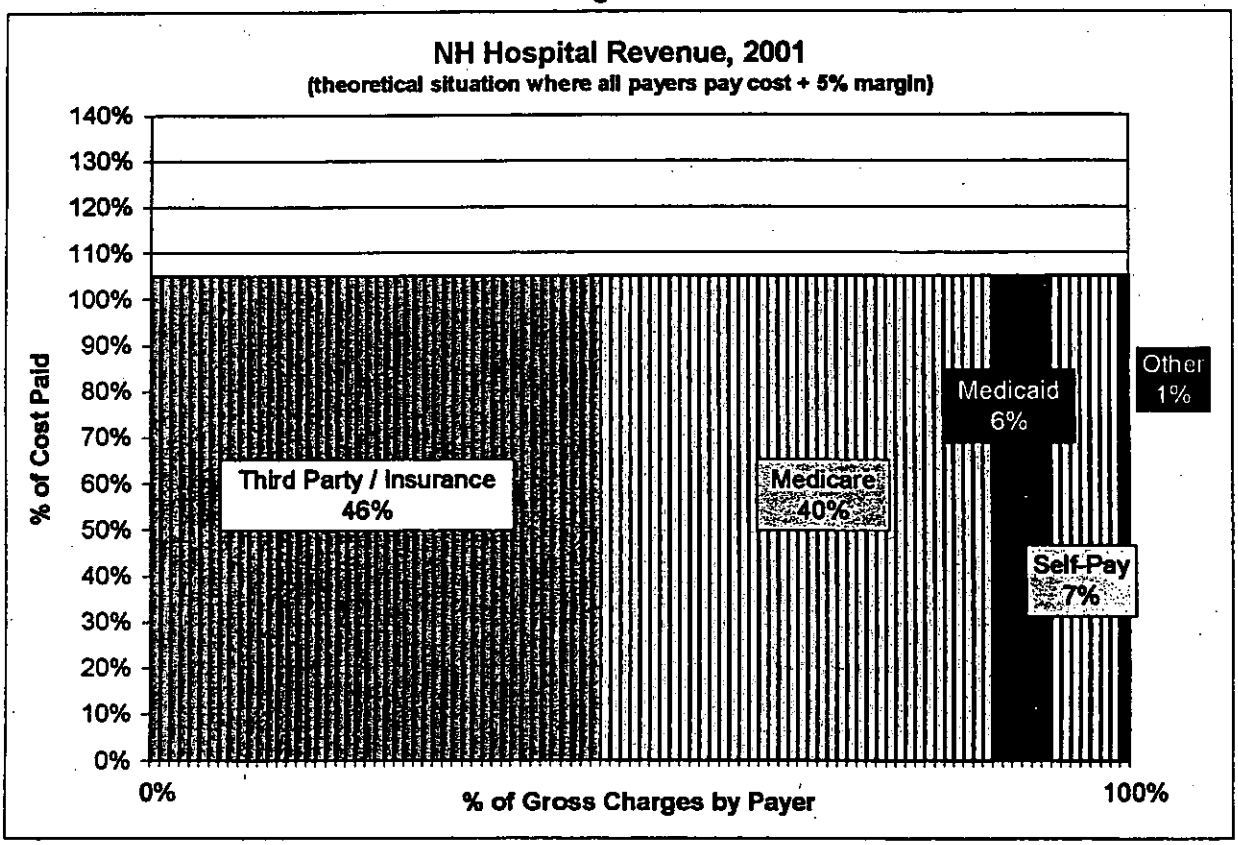
[7] This is obtained from the financial reports hospitals submitted to the NH Hospital Association.

7. The Base Case and the 'Hydraulics' Diagram

As noted above, major payers do not pay full charges, but benefit from some discount to charges. If all payers (including charity care cases now receiving care at no charge and persons responsible for the bad debt that is being written off) actually paid 105 percent of the real cost, hospitals would have an operating margin of 5 percent.

Figure 5, a "hydraulics" diagram[8], displays such a theoretical payment environment for New Hampshire's hospitals. The horizontal axis represents the percent of gross charges by payer. There are 100 narrow vertical bars on the chart. Each 1 percent of gross charges is represented by one vertical bar; for example, the left-most 46 bars represent the payments that hospitals receive from third-party insurance. The 6 percent of gross charges attributable to Medicaid patients are represented by 6 vertical bars farther to the right on the chart. This chart shows each payer paying exactly 105 percent of cost for all patients.

Figure 5



Under this scenario, the hospitals would have generated $1,708,835,180 in patient revenue in 2001 to cover their $1,627,462,076 real operating costs and also provide $81,373,104 of margin. In this situation, no cost-shifting would be occurring: each and every payer would be paying its share of costs plus margin.

[8] The design of the hydraulics diagram, as well as its name, were first brought to the author's attention by Al Dobson of The Lewin Group, in "Cost Shifting: An Integral Aspect of U.S. Health Care Finance," November 13, 2002.

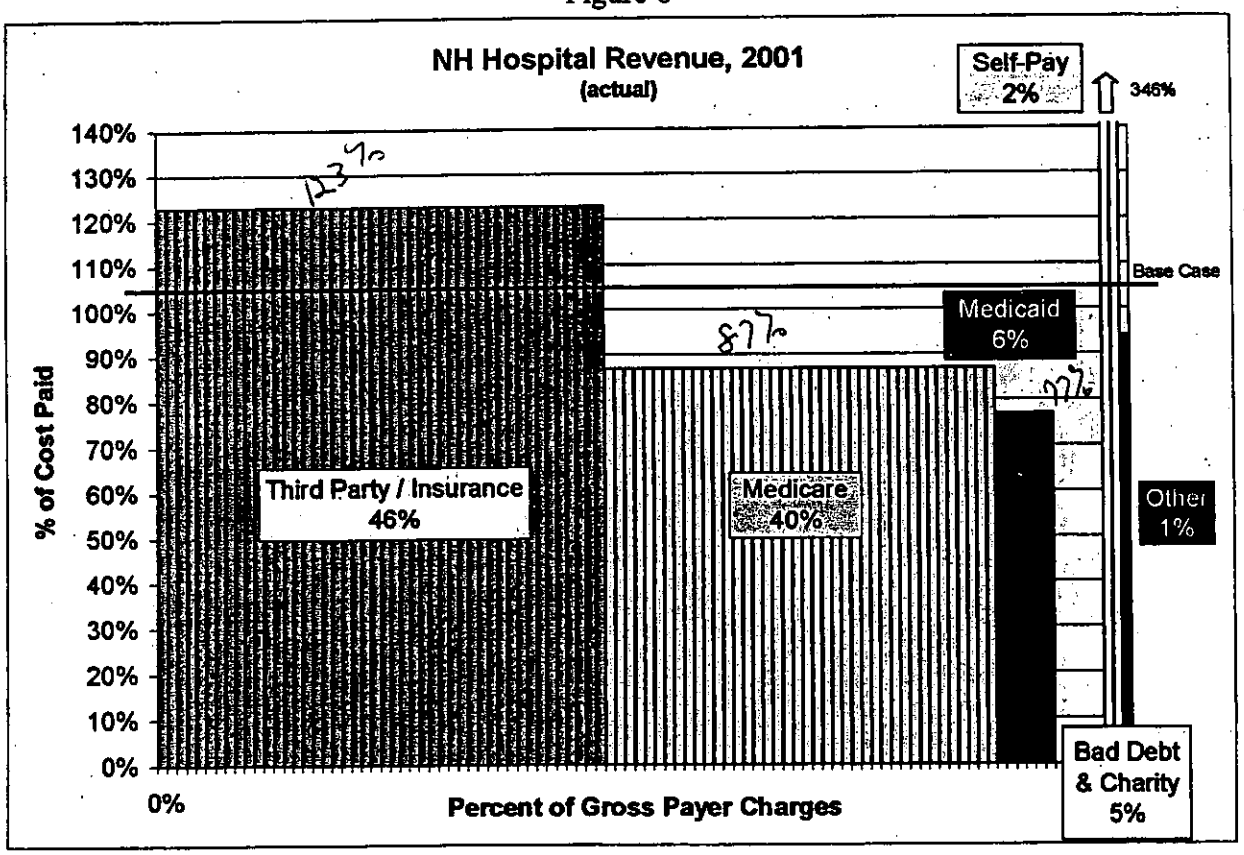
8. The Actual Situation in 2001

The actual situation was quite different as shown in Table 3 and Figure 6.

Table 3

Payment Source	% of Gross Charges	Net revenue received	Allocation of real operating expenses on basis of gross charges	Allocation of real operating expenses + 5% margin	Net revenue as % of expense share
Third Party	45.8%	$916,840,046	$745,467,561	$782,740,939	123.0%
Medicare	39.7%	$559,189,410	$646,137,479	$678,444,353	86.5%
Medicaid	6.6%	$82,259,512	$106,635,227	$111,966,988	77.1%
Charity Care	1.6%	$0	$26,251,452	$27,564,024	0.0%
Bad debt	3.4%	$0	$55,240,380	$58,002,399	0.0%
Self-pay	1.6%	$91,660,528	$26,507,663	$27,833,046	345.8%
Other Government + Other	1.3%	$19,864,074	$21,222,314	$22,283,430	93.6%
TOTAL	100.0%	$1,669,813,570	$1,627,462,076	$1,708,835,180	102.6%

Figure 6

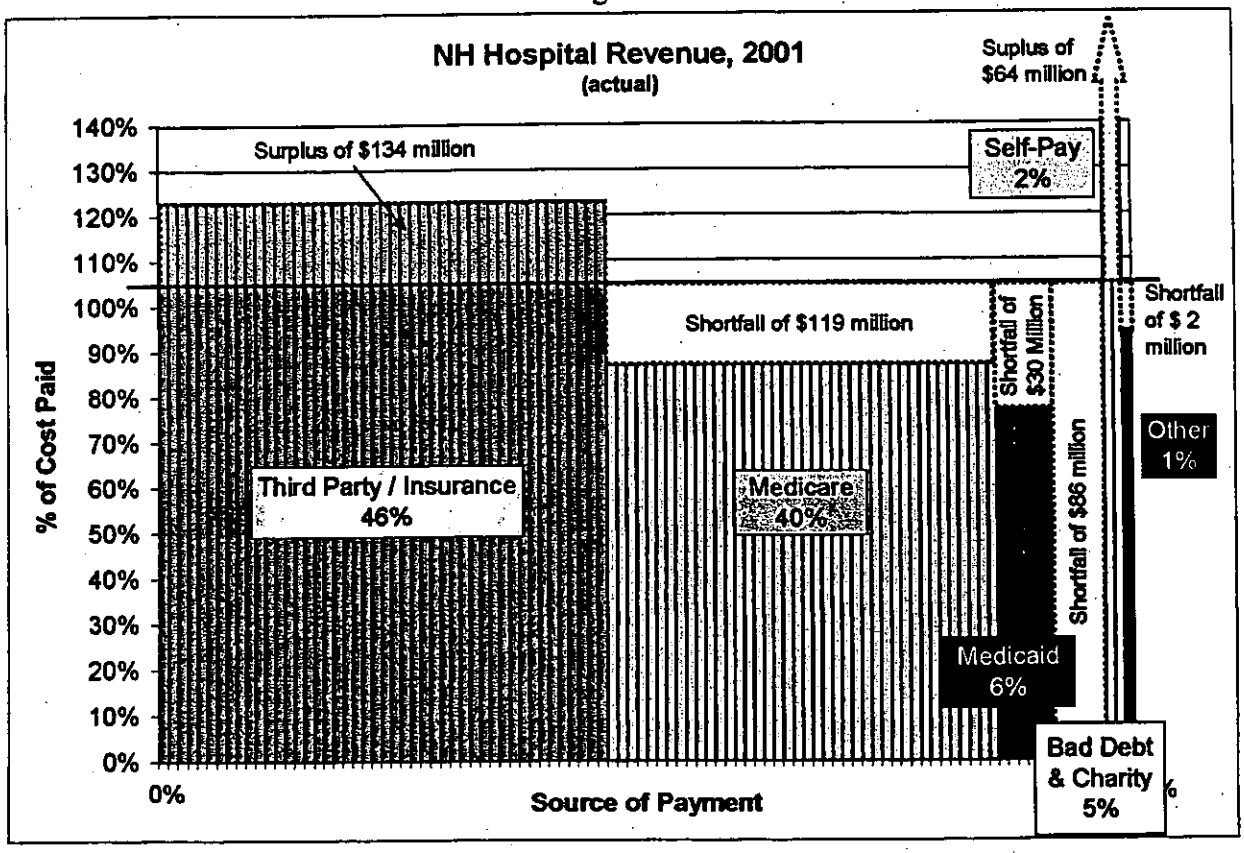


On average, third-party/insurance payers paid 123 percent of their share of actual expenses while Medicare paid 87 percent and Medicaid paid only 77 percent.[9] This means that insurance payments were 18 percent above what would be expected if they were to pay their share of expenses plus margin. One can think of this as an indirect and hidden "tax" or subsidy.

The figure and table show "self-pay" covering 346 percent of costs, a proportion that may be somewhat misleading. Payments directly from individuals is a more complicated. The hospitals received no revenue for the charges represented by bad debt and charity care. They did receive $91 million in payments from individuals. Some charges for services were partially paid and partially written off. Unfortunately, there are no data regarding what portion of a given individual's charges was actually paid. Thus, in Figure 6, one could consider that some of the self-pay amount should actually fill in some of the empty space above the bad debt and charity portion. However, we do not know how much should be so represented from the data available.

The size of the rectangles above or below the base cost line in Figure 6 are proportional to the cost shift from one payer type to another. Excess payments by one set of payers are used to offset the shortfalls caused by other payers. This is shown more clearly in Figure 7 where the $ volume of each rectangle is included.

Figure 7



[9] For year 2000 the American Hospital Association reported aggregate payment-to-cost ratio of New Hampshire hospitals to be 0.91 for Medicare, 0.682 for Medicaid, and 1.267 for all private-payers. Thus, our results are fairly close to those calculated by the AHA for the prior year.

Bad debt and charity cases fell short of their ideal share by $86 million. Medicaid fell short by $30 million. Medicare paid a higher percentage of its share but because it covered so many more services for so many more people, it fell short of its share by $119 million. A small $2 million shortfall occurred in the "Other" category. These shortfalls are shown in Table 4 and total $237 million.

Table 4

Payer	Actual Revenue	Revenue Needed to Meet Expenses Plus 5% Margin	Excess or (Shortfall)
Shortfalls			
Medicare	$559,189,410	$678,444,353	($119,254,943)
Medicaid	$82,259,512	$111,966,988	($29,707,476)
Bad Debt/Charity Care	$0	$85,566,423	($85,566,423)
Other	$19,864,074	$22,283,430	($2,419,356)
		Total	**($236,948,198)**
Surpluses			
Insurance	$916,840,046	$782,740,939	$134,099,107
Self-Pay	$91,660,528	$27,833,046	$63,827,482
		Total	**$197,926,588**
		Remaining shortfall	**($39,021,610)**
Operating margin			
Theoretical operating margin		5.0%	$81,373,104
Actual margin		2.6%	$42,351,494
Reduced margin			**$39,021,610**

Third-party insurers paid $134 million in excess of their 105 percent while self-pay generated a surplus of $64 million. The remaining $39 million was made up by the hospitals themselves through a reduced operating margin. They did not achieve our theoretical margin of 5 percent.[10]

A non-profit hospital can operate on less than a 5 percent margin and the community it serves may see little difference, especially in the short run. However, if continued for many years, lower margins may prevent the hospital from making investments in new facilities or technology. Some hospitals may make up lost margin through fund-raising, profits from ancillary non-medical services, or special grants. Hospitals owned by profit-making corporations need to generate a somewhat greater margin as they must pay federal and state business taxes on net income and still return profit to investors. If the return on investment is insufficient, hospital corporations will not be attractive investments.

[10] The observant reader will note a difference between the cited 2.6 percent operating margin in Table 4 and the 4.1 percent margin cited in Table 1. Table 4 is based on the data in the American Hospital Association survey, while Table 1 is based on data submitted by the hospitals to the NH Hospital Association. We cannot fully explain the difference.

In 2001 New Hampshire's 26 hospitals shifted costs among their patient groups and payers totaling some $237 million. To cover that amount third-party insurance paid $134 million above its share of cost plus margin, individuals paying directly for their care covered an additional $64 million, and the hospitals "ate" the remaining $39 million by operating with margins below 5 percent.

Medicare is the largest contributor to cost-shifting in New Hampshire's hospitals and contributes in aggregate four times the amount to the total cost shift as Medicaid.

While insurers negotiate discounts from standard charges from the hospitals, the resulting insurance payments for claims includes $134 million to cover cost-shifting. This is essentially a hidden tax of 17 percent. This hidden tax on hospital claims is passed on to employers and employees through the premiums they pay for health insurance.

9. Individual Hospitals

The calculations above represent the aggregate of all 26 community acute-care hospitals. The relative amount of cost-shifting at any given hospital may be more or less. Hospitals with higher percentages of Medicare and Medicaid patients, for example, are engaged in more cost-shifting and typically have lower operating margins. Some hospitals operated at a loss in 2001.

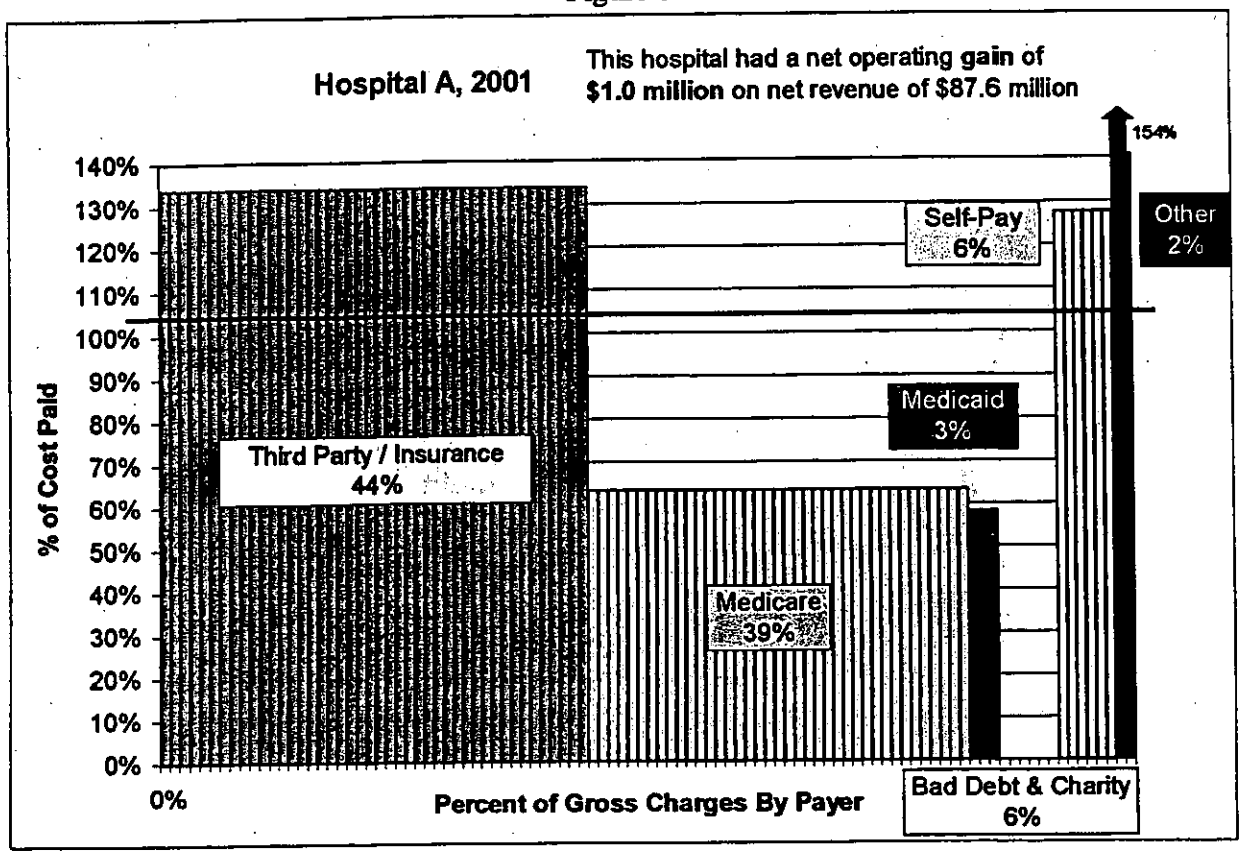
This section graphs the situation of four actual New Hampshire hospitals, using their own financial data for 2001. The four are illustrative of the variations across hospitals in patient mix and overall financial well-being. Because the examples are included to illustrate the general points of this paper, we identify them only as Hospitals A through D.

Hospital A

This hospital was operating very close to "break-even" in 2001. It had a net operating margin of only 1.1 percent. Figure 8 displays the data for this hospital.

The percentage of gross charges that are made to insurance companies are about the same as for the average hospital shown in Figure 6 (44 percent for Hospital A and 46 percent for the average). Medicare, too, represents about the same proportion of gross charges as it does for the average hospital. Note that Medicaid, however, represents a smaller percentage of gross charges (3 percent compared to 6 percent for the average hospital) while self-pay represents a greater percentage (6 percent versus 2 percent).

Figure 8



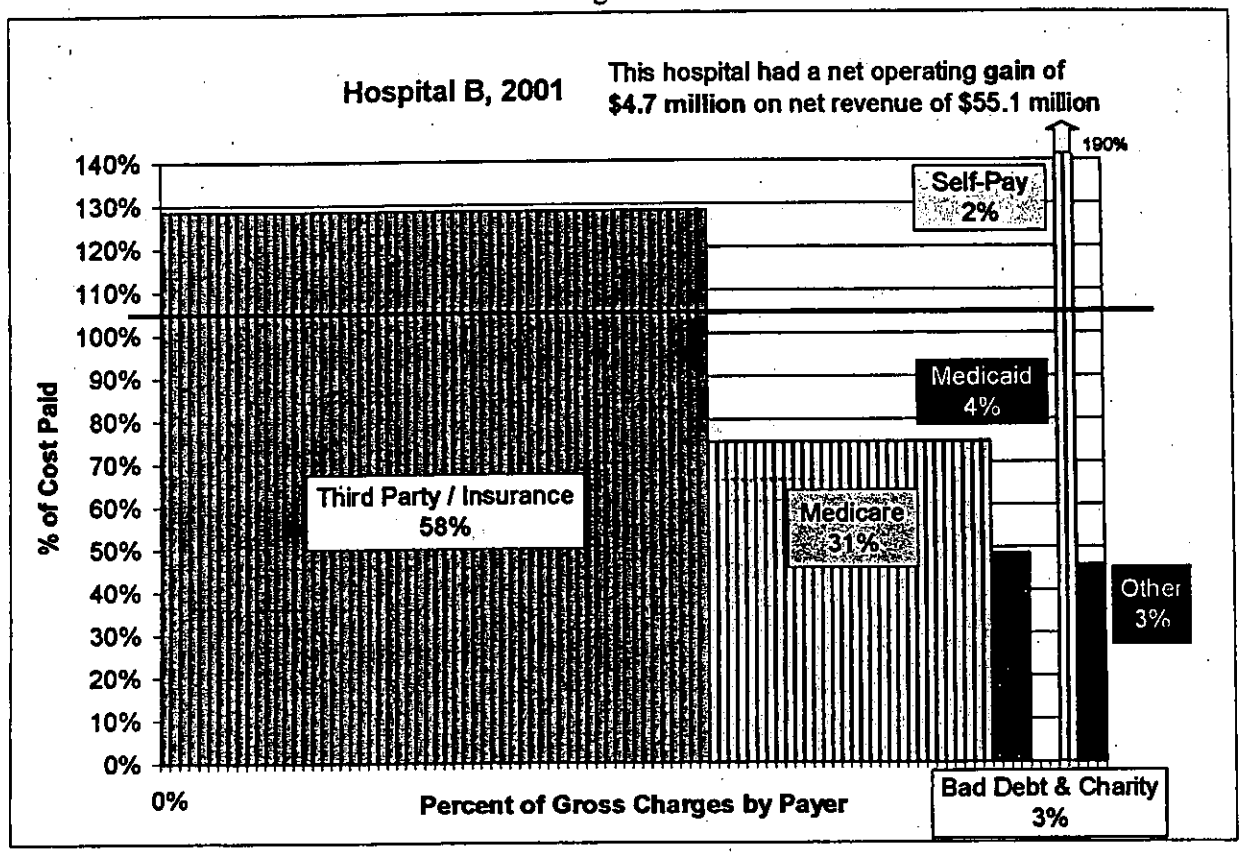
For this hospital, Medicare is only making payments that represent 62 percent of cost (for the average hospital it is 86 percent), thus resulting in a larger amount of deficit that must be filled by excess revenue from others. Insurance payments do fill much of that, representing 134 percent of cost in comparison to 123 percent for the average hospital.

Visually, one can see that the amounts in excess of 105 percent just about balance the amounts of shortfall from other payment sources.

Hospital B

This hospital had a solid operating gain in 2001. Its margin was 9.1 percent. Figure 9 shows how that margin of revenue over expense was achieved. Medicare represented only 31 percent of the gross charges for this hospital. Medicaid, charity care, and bad debt together represented only 7 percent of gross charges while they represented 11 percent of the average hospital's gross charges.

Figure 9



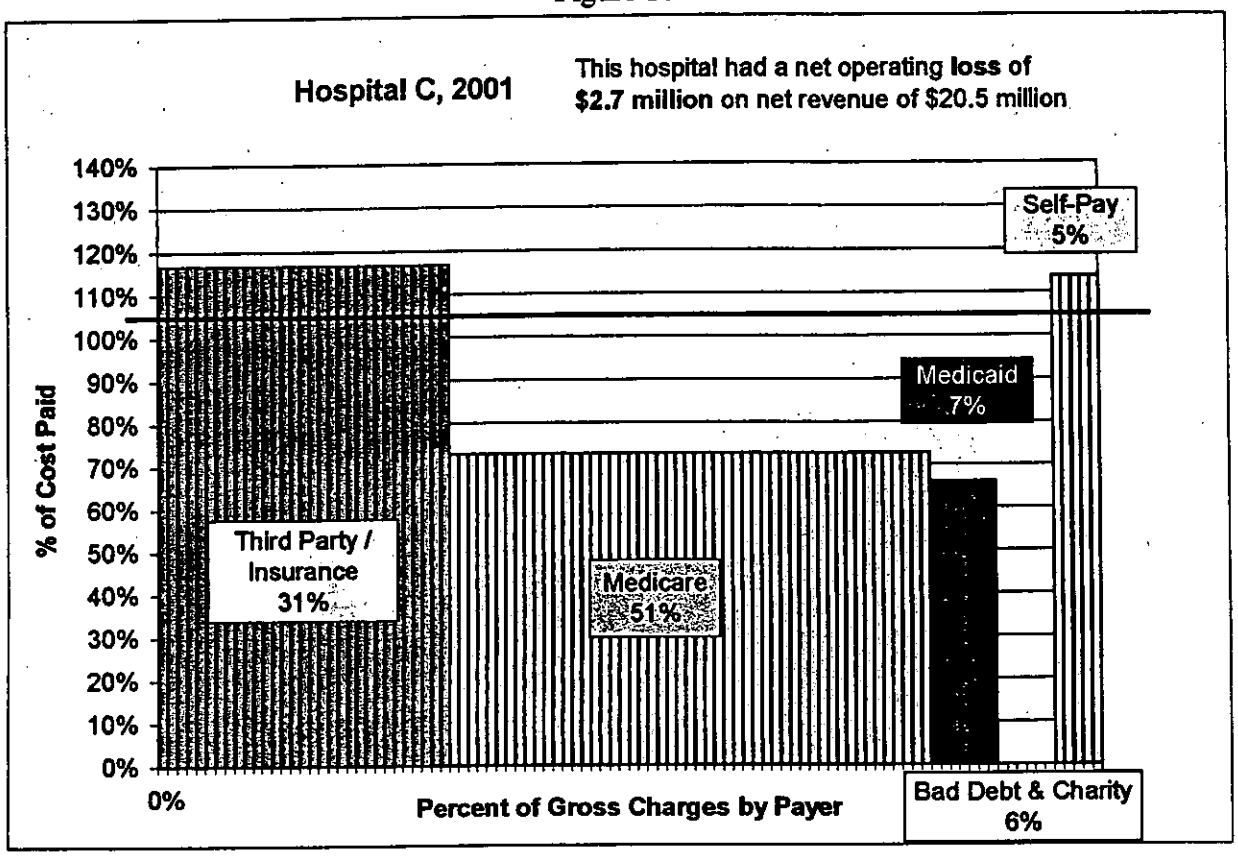
Insurance payers paid 128 percent of cost, slightly more than the state average. Because they constituted a larger percentage of charges as well, they contributed considerably more excess revenue toward the hospital's shortfalls from other payment sources.

Hospital C

This hospital was operating in the red in 2001. Its operating revenue was inadequate to cover its operating costs. Not only did it not achieve our theoretical operating margin of 5 percent, it had an operating margin of –11.7 percent. Its revenue was far short of what was needed to support its expenses.

Figure 10 shows why this was the case. Medicare represented 51 percent of gross charges while charges billed to insurance companies represented only 31 percent. The amount of excess revenue obtained from insurance companies and self-pay sources were grossly inadequate to cover the losses from Medicare, Medicaid, bad debt, and charity care.

Figure 10



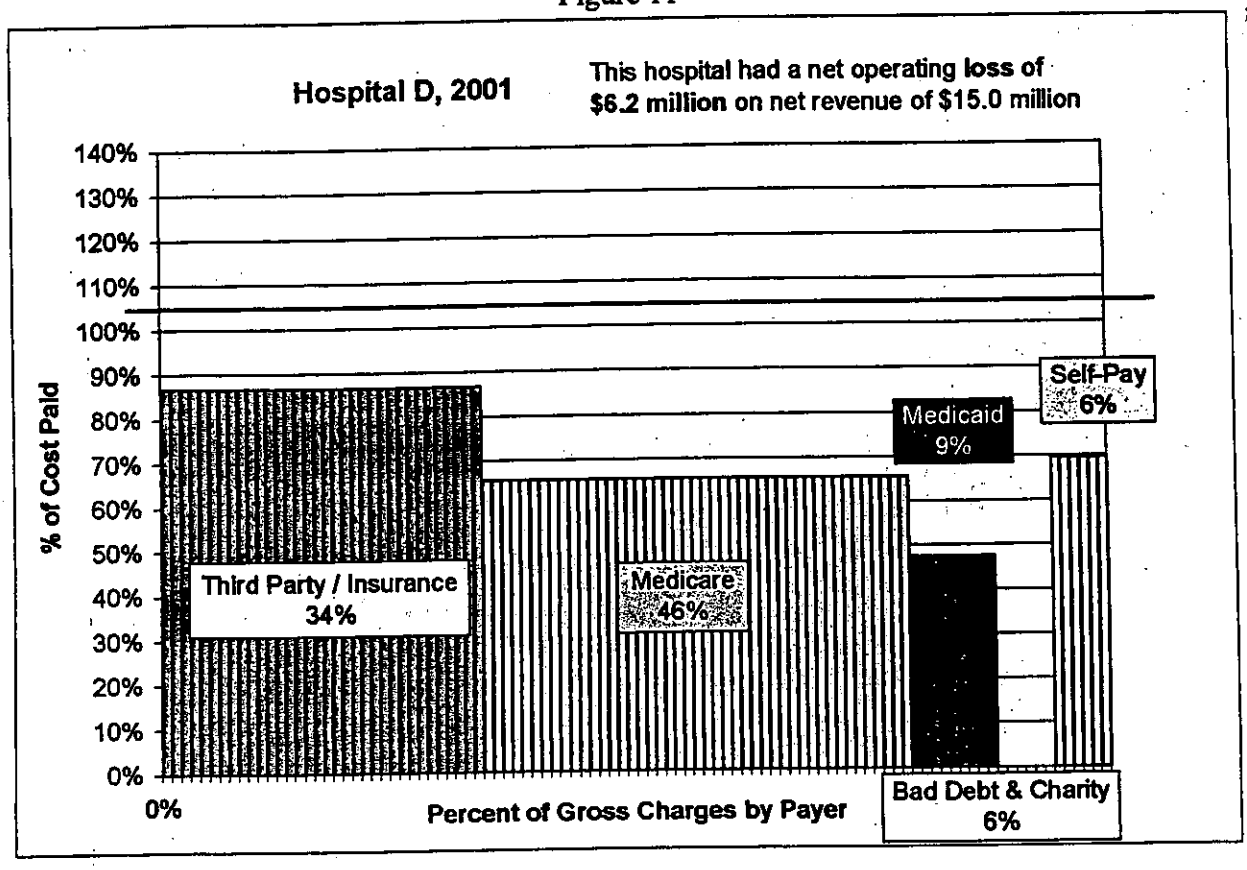
Comparing Hospital C with Hospital B indicates that the difference in patient mix (as represented by percent of gross charges billed to different sources) is largely responsible for the fact that Hospital C was operating at a large loss while Hospital B was able to operate with a healthy margin.

Hospital D

A quick glance at Figure 11 tells the story for this hospital. Not one source of payment for services was covering its costs. Every payer category was contributing to loss. There was no source of revenue to cover the cost-shifting caused by Medicare, Medicaid, bad debt, and charity care. In 2001 this hospital had an operating margin of –29.3 percent.

Obviously the operation of this hospital under these financial conditions could not continue for long.

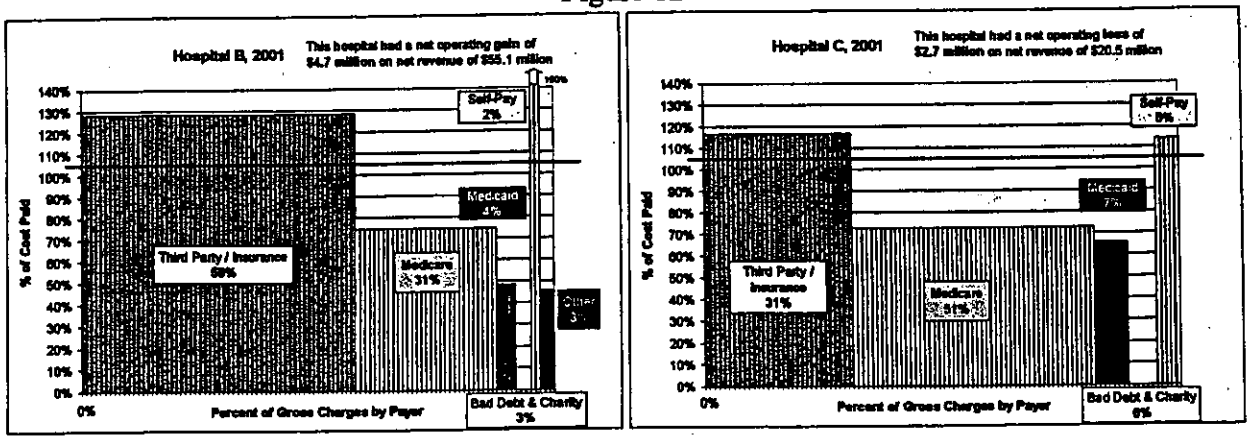
Figure 11



10. A Problem in Making Comparisons

While the hydraulics diagram of each hospital is a striking visual that fairly presents the status of finance in *that* hospital, it is not appropriate to compare two charts side by side. Such a possible comparison is shown in Figure 12. The problem lies in the vertical axis.

Figure 12



The vertical axis in these two charts is "% of Cost Paid." Because each hospital's cost structure is different, 100 percent of cost on the left hand chart does not necessarily represent the same

whether the differences are because one hospital's cost structure is higher or because the amount it receives in payment for services is lower.

We are currently unable to make a comparison using a vertical axis stated in absolute terms so that hospitals can be compared. The reason we cannot do so is that the information needed to calculate and display the data is not available to us.

11. More Data Required for Better Understanding

Further important analysis could be done on hospital finance.

How much cost-shifting is caused by higher than average cost structures?
How much cost-shifting is caused by lower than average payments?
How do charges and payments relate to average cost for different procedures?
What portions of gross charges are derived from which procedures and services?
Which services and procedures generate the most excess revenues?
Which services are "loss leaders?"

Answers to these questions and others would inform discussion of the kinds of policies needed to ensure continued support for workforce health insurance and adequate public programs that ensure access to services for those who are uninsured.

In regard to hospital finance, three types of data are needed for each hospital:

- The hospital's master list of charges;
- A count of the number of charges made for each charge type over each 12 month period;
- The amounts actually received as payment for each charge type from larger payment sources for which some amount less than charge is accepted as payment.

These data are available to each hospital. Without them, a hospital could not bill for the treatments and services it provides, nor could it credit income received against billed revenue. Currently hospitals assert that these data are private and proprietary and that disclosure might adversely affect competitive situations or violate anti-trust laws. Also, some of these data are protected by non-disclosure clauses in agreements negotiated between hospitals and insurers.

If health care is to function as a market-driven system – as some argue it should – it must provide price signals that inform and potentially impact behavior: behavior of consumers of health care, competitive behavior of providers, and payment behavior of third-parties, including public programs and commercial insurers. Currently the necessary price and cost information is not easily available to the public.

We urge release of the types of data identified here. While there is currently no legal requirement that such information be publicly available, employers (who ultimately fund much of health care through the premiums they pay for insurance for their employees) could request that this type of information be made available to them by their insurers and by the health care institutions that serve their communities.

In addition, we also urge hospitals to serve their communities – and health care policy generally – by summarizing and disclosing their cost-shifting information regularly and in an easily understandable format. In its annual report, each hospital should present a table similar to Table 4 and a "hydraulics diagram" like the ones presented in this report. These could be prepared or reviewed by the hospitals' auditing firms.[11]

12. Data Sources

The NH Hospital Association provided financial data on all hospitals for 2001 and earlier years. They loaned copies of the audited financial reports of the hospitals to the Center and also provided copies of NHHA Excel spreadsheets containing annual financial data.[12]

Additional data were obtained from unpublished tables and analysis prepared by The Lewin Group based on the American Hospital Association's Year 2000 Annual Survey of community hospitals.

Useful insights and background material can be found in "The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis," Office of Planning and Research, NH Department of Health and Human Services, December 13, 2000. The most relevant paper for this project that is contained in that report is "Analysis of Health Care Charitable Trusts in the State of New Hampshire: The Hospital Sector" by Nancy M. Kane.

[11] In 2001, eight auditing firms were employed by 24 acute care hospitals: Baker, Newman & Noyes; Berry, Dunn, McNeil &Parker; Dana S. Beane & Co.; Ernst & Young; KPMG; Price Waterhouse Coopers; Robin R. Grill; Tyler, Simms, & St. Saveur. As component parts of national profit-making firms, two of the hospitals do not have separately reported finances, but could still voluntarily disclose such information.

[12] Hospitals do not all share the same fiscal year. Some end on June 30, some on September 30, and some on December 31. The fiscal year totals across all hospitals are not, therefore, equal to figures reported by Medicare or Medicaid which use federal fiscal years (October-September) or state fiscal years (July-June). Some hospitals are part of a larger corporate entity that may include other functions such as home nursing or community health education. In those cases, the data used represents only the hospital's finances.

Voting Sheets

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 470

BILL TITLE: **relative to health insurance providers.**

DATE: March 18, 2003

LOB ROOM: 302

Amendments:

Sponsor: Rep. Brady — OLS Document #: 2003 0728h

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

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

Moved by Rep. Liebl

Amendment

Seconded by Rep. Brady

Vote: 17-1 (Please attach record of roll call vote.)

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

Moved by Rep. Liebl

Seconded by Rep. Brady

Vote: 18-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 18-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Paul D. Spiess, Clerk

OFFICE OF THE HOUSE CLERK 2003 SESSION

COMMERCE

Bill #: 470 **Title:**

PH Date: / / **Exec Session Date:** 3 / 18 / 03

Motion: Adopt Amendment **Amendment #:** 0728h

MEMBER	YEAS	NAYS
Hunt. John B. Chairman		
Fraser. Leo W. V Chairman	✓	
Francoeur. Sheila T		
Belanger. Ronald J		
Langley. Jane S	✓	
DiFruscia. Anthony R	✓	
Flanders. Donald H	✓	
Spiess. Paul D	✓	
Holden. Randolph N	✓	
Liebl. George J	✓	
Quandt. Matthew J	✓	
Clark. Charles L	✓	
Brady. Mark A	✓	
Scamman. Stella	✓	
Stepanek. Stephen B	✓	
Reardon. Tara G	✓	
Taylor. Kathleen N	✓	
Meader. David R	✓	
DeStefano. Stephen T	✓	
Vachon. Dennis P		✓
Kopka. Angeline A	✓	
	17	1

TOTAL VOTE:

Printed: 1/6/2003

OFFICE OF THE HOUSE CLERK

2003 SESSION

COMMERCE

Bill #: 470 **Title:**

PH Date: / / **Exec Session Date:** 3 / 18 / 03

Motion: OTPA **Amendment #:** 0281

MEMBER	YEAS	NAYS
Hunt. John B. Chairman		
Fraser. Leo W. V Chairman	✓	
Francoeur. Sheila T	✓	
Belanger. Ronald J		
Langley. Jane S	✓	
DiFruscia. Anthony R	✓	
Flanders. Donald H	✓	
Spiess. Paul D	✓	
Holden. Randolph N	✓	
Liebl. George J	✓	
Quandt. Matthew J	✓	
Clark. Charles L	✓	
Brady. Mark A	✓	
Scamman. Stella	✓	
Stepanek. Stephen B	✓	
Reardon. Tara G	✓	
Taylor. Kathleen N	✓	
Meader. David R	✓	
DeStefano. Stephen T	✓	
Vachon. Dennis P	✓	
Kopka. Angeline A	✓	
	18	0

TOTAL VOTE:

Printed: 1/6/2003

Committee Report

COMMITTEE REPORT

COMMITTEE: **Commerce**

BILL NUMBER: **HB 470**

TITLE: relative to health insurance providers.

DATE: March 18, 2003 CONSENT CALENDAR YES ☒ NO ☐

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

This legislation as introduced would address "any willing provider" to be accepted by health insurers. The bill also requires health insurers to keep a provider's personal information confidential. The committee heard testimony that the insurance department opposed the willing provider issue as too broad in scope. As amended the bill does address the confidentiality issue.

Vote 18-0.

Rep. George J. Liebl
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

CONSENT CALENDAR

Commerce

HB 470, relative to health insurance providers. **OUGHT TO PASS WITH AMENDMENT**

Rep. George J. Liebl for Commerce: This legislation as introduced would address "any willing provider" to be accepted by health insurers. The bill also requires health insurers to keep a provider's personal information confidential. The committee heard testimony that the insurance department opposed the willing provider issue as too broad in scope. As amended the bill does address the confidentiality issue. **Vote 18-0.**

HB 478 RELATIVE TO HEALTH INSURANCE PROVIDERS

Rep. GEORGE J. LIEBL FOR COMMERCE OTP WITH AMENDMENT

THIS LEGISLATION AS INTRODUCED WOULD ADDRESS "ANY WILLING PROVIDER" TO BE ACCEPTED BY HEALTH INSURERS. THE BILL ALSO REQUIRES HEALTH INSURERS TO KEEP A PROVIDERS PERSONAL INFORMATION CONFIDENTIAL. COMMITTEE HEARD TESTIMONY THAT THE INS. DEPT OPPOSED THE WILLING PROVIDER ISSUE AS TOO BROAD IN SCOPE. AS AMENDED THE BILL DOES ADDRESS THE CONFIDENTIALITY ISSUE. VOTE 18-0

GEORGE J. LIEBL