Bill as Introduced

SB 110 – AS AMENDED BY THE SENATE

04/03/03 0993s
04/03/03 1134s

2003 SESSION

03-0290
01/09

SENATE BILL ***110***

AN ACT relative to small group health insurance coverage.

SPONSORS: Sen. Prescott, Dist 23; Sen. Clegg, Dist 14; Sen. Eaton, Dist 10; Sen. Flanders, Dist 7; Sen. Morse, Dist 22; Rep. Rogers Johnson, Rock 83; Rep. M. Carter, Hills 44; Rep. Letourneau, Rock 77; Rep. R. Wheeler, Hills 48

COMMITTEE: Insurance

ANALYSIS

This bill revises the laws relative to small group health insurance. The bill changes the definition of small group employer to employers with 2-50 employees. Current law defines small group employers to have 1-100 employees.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Three

AN ACT relative to small group health insurance coverage.

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

1 Definition; "Community Rate." RSA 420-G:2, I is repealed and reenacted to read as follows:

I. "Community rate" means a single rate reflecting the carrier's average cost of actual or anticipated claims for all health coverages or health benefit plans the carrier writes and maintains in a market, including the nongroup individual health insurance market and the small employer group health insurance market.

2 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph IX the following new paragraph:

IX-a. "Health coverage base rate" means a rate that is uniquely determined for each of the coverages or health benefit plans a health carrier writes and that is derived from the community rate through the application of factors that reflect actuarially demonstrated differences in expected utilization or cost attributable to differences in the coverage design and/or the provider contracts that support the coverage.

3 Definition of Large Employer. Amend RSA 420-G:2, XII(a) to read as follows:

XII.(a) "Large employer" means an employer that employed on average at least [~~101~~] ***51*** persons, on business days, during the previous calendar year.

4 Definition of a Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to [~~100~~] ***50*** employees, including owners and self-employed persons, on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

5 Premium Rates for Small Employers. RSA 420-G:4, I is repealed and reenacted to read as follows:

I. Health carriers providing health coverage to individuals and small employers under this chapter shall be subject to the following:

(a) All premiums charged shall be guaranteed for at least 6 months.

(b) Community rate shall be established by each health carrier for all of its health coverages offered to individuals and, separately, for all of its health coverages offered to small employers.

(c) Health carriers shall calculate health coverage base rates for each of the coverages or health benefit plans written by that carrier. Variations in health coverage base rates shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

(d) In establishing the premium charged, health carriers providing coverage to individuals shall calculate a rate that is derived from the health coverage base rate through the application of rating factors that the carrier chooses to utilize for age, health status, and tobacco use. Such factors may be utilized only in accordance with the following limitations:

(1) The maximum premium differential for age as determined by ratio shall be 4 to 1. The limitation shall not apply for determining rates for an attained age of less than 19.

(2) The maximum differential due to health status shall be 1.5 to 1 and the maximum differential rate due to tobacco use shall be 1.5 to 1. Rate limitations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(3) Permissible rating characteristics shall not include changes in health status after issue.

(e) In establishing the premium charged, health carriers providing coverage to small employers shall calculate a rate that is derived from the health coverage base rate through the application of rating factors that the carrier chooses to utilize for age, group size, industry classification, geographic location, and health status. Such factors may be utilized only in accordance with the following limitations:

(1) Carriers may use the attained age of covered persons as a rating factor. However, the maximum premium differential for age as determined by ratio shall be 4 to 1 beginning with age 19.

(2) Carriers modifying such average premium for age may do so only by using the following age brackets:

0 - 18
19 - 24
25 - 29
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55 - 59
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(3) Carriers may use group size as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 20 percent; provided that for groups of one, an additional 10 percent rating factor shall be allowed from the highest factor.

(4) Carriers may use the small employer group's industry classification as a rating factor. However, the highest factor based on industry classification shall not exceed the lowest factor based on industry classification by more than 20 percent.

(5) Carriers may use the small employer group's geographic location as a rating factor. However, the highest factor based on geographic location shall not exceed the lowest factor based on geographic location by more than 15 percent.

(6) Carriers may use the health status of the small employer group as a rating factor. However, the application of a health status factor shall be subject to the following limitations:

(A) The health status factor may reflect health status of covered persons, the small employer's claim experience, or the duration of coverage since health statements were last provided.

(B) Variations from the arithmetic average of the highest rate charged to the lowest rate charged shall not exceed 25 percent.

(C) Upon the renewal of a small employer policy, any increase in the premium rate that is solely attributable to changes in the health status factor from the prior year shall be no more than 15 percent.

(7) Upon the renewal of a small employer policy, a carrier is prohibited from increasing the premium rate by more than 25 percent of the rate that was charged in the preceding year. Such rate increase limitation shall not include any premium rate increase that is based on a carrier's annual cost and utilization trends or changes in the rating factor for attained age of covered persons. This subparagraph shall expire on January 1, 2005.

(f) The same rating methodology shall apply to newly covered individuals and to individuals renewing at each annual renewal date, or to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

(g) The commissioner shall not approve any filing if such filing is excessive, inadequate or contrary to the intent of this chapter.

6 Medical Underwriting. RSA 420-G:5 is repealed and reenacted to read as follows:

420-G:5 Medical Underwriting.

I Health carriers providing health coverage for individuals or small employer groups may perform medical underwriting, including the use of health statements or screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4. Such underwriting may be limited to the use of a standardized health statement for use in adjustments to rating pursuant to RSA 420-G:4. The commissioner may, by rule, require carriers to use a standardized health statement.

II. Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status. Regardless of claim experience, health status, or medical history, health carriers providing health coverage for small employers shall not refuse to write or issue any of their currently available coverages or health benefit plans to any small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

III. Health carriers providing health coverage for small employer groups shall not knowingly provide health coverage to groups where the employer has discriminated based on health status or claims history against any employee or potential employee or his or her dependents with respect to participation in an employer-sponsored health benefit plan.

IV. Health carriers shall not offer riders or endorsements to exclude certain illnesses or health conditions in order to avoid the purpose of this chapter.

V. Individual health insurance carriers shall be responsible for ascertaining the eligibility of any individual applicant or insured for high risk pool coverage. If a carrier determines that an individual meets any of the eligibility criteria set forth in RSA 404-G:5-e, the carrier shall give the individual written notice, with the declination of coverage, the coverage offering or upon a rate increase at renewal. The notice shall include information about available benefits and exclusions of high risk pool coverage and the name, address, and telephone number of the pool administrator or the administrator's designee.

VI. It shall constitute an unfair trade practice under RSA 417 for an insurer, insurance producer, or third party administrator to refer an individual employee to the pool, or arrange for an individual employee to apply to the pool, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

7 Qualified Association Trust. RSA 420-G:10 is repealed and reenacted to read as follows:

420-G:10 Qualified Association Trust.

I. A qualified association trust or other entity, as defined in RSA 420-G:2, XV, shall:

(a) Employ the rating methodology outlined in RSA 420-G:4 for all small employer members with 50 or fewer employees based upon the association's group experience.

(b) Offer all eligible members, as defined under the applicable trust or other documents, coverage and rates on a guaranteed issue and renewable basis.

(c) Comply with the regulations concerning medical underwriting in RSA 420-G:5.

(d) Comply with the preexisting conditions provision of RSA 420-G:7.

II. Nothing in this chapter shall be interpreted to limit the size of employers who may participate in coverage with a qualified association trust.

8 Repeal. RSA 420-G:8, I(b), relative to medical underwriting, is repealed.

9 Effective Date. This act shall take effect July 1, 2003.

Amendments

Rep. Brady, Coos 2
May 19, 2003
2003-1692h
09/10

Amendment to SB 110

Not used

Amend the title of the bill by replacing it with the following:

AN ACT relative to small group health insurance coverage and relative to health plan loss information.

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

1 Definition; "Base Rate." RSA 420-G:2, I is repealed and reenacted to read as follows:

I. "Base rate" means a single rate reflecting the carrier's average cost of actual or anticipated claims for all health coverages or health benefit plans the carrier writes and maintains in a market, including the nongroup individual health insurance market and the small employer group health insurance market.

2 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph IX the following new paragraph:

IX-a. "Health coverage plan rate" means a rate that is uniquely determined for each of the coverages or health benefit plans a health carrier writes and that is derived from the base rate through the application of factors that reflect actuarially demonstrated differences in expected utilization or cost attributable to differences in the coverage design and/or the provider contracts that support the coverage.

3 Definition of Large Employer. Amend RSA 420-G:2, XII(a) to read as follows:

XII.(a) "Large employer" means an employer that employed on average at least [~~101~~] ***51*** persons, on business days, during the previous calendar year.

4 Definition of a Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to [~~100~~] ***50*** employees, including owners and self-employed persons, on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

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(a) All premiums charged shall be guaranteed for at least 6 months.

(b) Base rate shall be established by each health carrier for all of its health coverages offered to individuals and, separately, for all of its health coverages offered to small employers.

(c) Health carriers shall calculate health coverage plan rates for each of the coverages or health benefit plans written by that carrier. Variations in health coverage plan rates shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

(d) In establishing the premium charged, health carriers providing coverage to individuals shall calculate a rate that is derived from the health coverage plan rate through the application of rating factors that the carrier chooses to utilize for age, health status, and tobacco use. Such factors may be utilized only in accordance with the following limitations:

(1) The maximum premium differential for age as determined by ratio shall be 4 to 1. The limitation shall not apply for determining rates for an attained age of less than 19.

(2) The maximum differential due to health status shall be 1.5 to 1 and the maximum differential rate due to tobacco use shall be 1.5 to 1. Rate limitations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(3) Permissible rating characteristics shall not include changes in health status after issue.

(e) In establishing the premium charged, health carriers providing coverage to small employers shall calculate a rate that is derived from the health coverage plan rate through the application of rating factors that the carrier chooses to utilize for age, group size, industry classification, and health status. Such factors may be utilized only in accordance with the following limitations:

(1) Carriers may use the attained age of covered persons as a rating factor. However, the maximum premium differential for age as determined by ratio shall be 4 to 1 beginning with age 19.

(2) Carriers modifying such average premium for age may do so only by using the following age brackets:

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(3) Carriers may use group size as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 20 percent; provided that for groups of one, an additional 10 percent rating factor shall be allowed from the highest factor.

(4) Carriers may use the small employer group's industry classification as a rating factor. However, the highest factor based on industry classification shall not exceed the lowest factor based on industry classification by more than 20 percent.

(5) Carriers may use the health status of the small employer group as a rating factor. However, the application of a health status factor shall be subject to the following limitations:

(A) The health status factor may reflect health status of covered persons, the small employer's claim experience, or the duration of coverage since health statements were last provided.

(B) Variations from the arithmetic average of the highest rate charged to the lowest rate charged shall not exceed 25 percent.

(C) Upon the renewal of a small employer policy, any increase in the premium rate that is solely attributable to changes in the health status factor from the prior year shall be no more than 15 percent.

(6) Upon the renewal of a small employer policy, a carrier is prohibited from increasing the premium rate by more than 25 percent of the rate that was charged in the preceding year. Such rate increase limitation shall not include any premium rate increase that is based on a carrier's annual cost and utilization trends or changes in the rating factor for attained age of covered persons.

(f) Each rating factor that a carrier chooses to utilize shall be reflective of claim cost variations that correlate with that factor independently of claim cost variations that correlate with any of the other allowable factors.

(g) The same rating methodology shall apply to newly covered individuals and to individuals renewing at each annual renewal date, or to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

(h) The commissioner shall not approve any filing if such filing is excessive, inadequate or contrary to the intent of this chapter.

6 New Paragraph; Premium Rates. Amend RSA 420-G:4 by inserting after paragraph II the following new paragraph:

III. A health carrier, when determining the premium charged to a large employer group that employs from 51 to 100 employees, shall calculate the rate using a weighted average calculation consisting of the group's experience and the carrier's large employer group pool experience. The weight used for the group's experience shall be no more than 25 percent and the weight used for the experience of the carrier's large employer group pool shall be a minimum of 75 percent.

7 Medical Underwriting. RSA 420-G:5 is repealed and reenacted to read as follows:

420-G:5 Medical Underwriting.

I Health carriers providing health coverage for individuals or small employer groups may perform medical underwriting, including the use of health statements or screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4. Such underwriting may be limited to the use of a standardized health statement for use in adjustments to rating pursuant to RSA 420-G:4. The commissioner may, by rule, require carriers to use standardized health statements.

II. Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status. Regardless of claim experience, health status, or medical history, health carriers providing health coverage for small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

III. Health carriers providing health coverage for small employer groups shall not knowingly provide health coverage to groups where the employer has discriminated based on health status or claims history against any employee or potential employee or his or her dependents with respect to participation in an employer-sponsored health benefit plan.

IV. Health carriers shall not offer riders or endorsements to exclude certain illnesses or health conditions in order to avoid the purpose of this chapter.

V. Individual health insurance carriers shall be responsible for ascertaining the eligibility of any individual applicant or insured for high risk pool coverage. If a carrier determines that an individual meets any of the eligibility criteria set forth in RSA 404-G:5-e, the carrier shall give the individual written notice, with the declination of coverage, the coverage offering or upon a rate increase at renewal. The notice shall include information about available benefits and exclusions of high risk pool coverage and the name, address, and telephone number of the pool administrator or the administrator's designee.

VI. It shall constitute an unfair trade practice under RSA 417 for an insurer, insurance producer, or third party administrator to refer an individual employee to the pool, or arrange for an individual employee to apply to the pool, for the purpose of separating that employee from group

health insurance coverage provided in connection with the employee's employment.

8 Qualified Association Trust. RSA 420-G:10 is repealed and reenacted to read as follows:

420-G:10 Qualified Association Trust.

I. A qualified association trust or other entity, as defined in RSA 420-G:2, XV, shall:

(a) Comply with the rating restrictions outlined in RSA 420-G:4 for all small employer members with 50 or fewer employees based upon the association's group experience, except that no rating factor shall be utilized without the express written consent of the association.

(b) Offer all eligible members, as defined under the applicable trust or other documents, coverage and rates on a guaranteed issue and renewable basis.

(c) Comply with the regulations concerning medical underwriting in RSA 420-G:5.

(d) Comply with the preexisting conditions provision of RSA 420-G:7.

II. Nothing in this chapter shall be interpreted to limit the size of employers who may participate in coverage with a qualified association trust.

9 Group Health Insurance; Health Plan Loss Information. RSA 420-G:12-a is repealed and reenacted to read as follows:

420-G:12-a Health Plan Loss Information.

I. To ensure maximum competition in the purchase of group health insurance, all private and public employers with at least 50 employees enrolled in their group health plan shall be entitled to receive their specific health plan loss information upon request and without charge. No contract between any health carrier, third-party administrator, employer group or pool of employers shall abridge this right in any manner.

II. Upon written request from any private or public employer with 50 or more employees enrolled in its group health plan, every health carrier, third-party administrator, pooled risk management program under RSA 5-B or any other type of multiple employer health plan shall provide that employer's loss information within 30 calendar days of receipt of the request. The loss information shall include all physician, hospital, prescription drug, and other covered medical claims specific to the employer's group plan incurred for the 12-month period paid through the 14 months which end within the 60-day period prior to the date of the request. An employer shall not be entitled by this section to more than 2 loss information requests in any 12-month period; however, nothing shall prohibit a carrier from fulfilling more frequent requests on a mutually agreed-upon basis.

III. If an employer requests loss information from an insurance agent or other authorized representative, including an administrator of a pooled risk management program or a multiple employer health plan, the agent or authorized representative shall transmit the request to the health carrier or carriers or third-party administrator within 4 working days.

10 Commissioner's Requested Information. Amend RSA 420-G:14-a to read as follows:

420-G:14-a Requested Information.

I. As authorized in accordance with RSA 420-G:14, the commissioner may request the submission of such information by carriers as is necessary to better understand the coverage history and choices of participants in the nongroup market. The commissioner shall make every attempt to ensure the reasonableness of such request, both in terms of scope and timeframe, and to limit this request to information the commissioner deems necessary to better understand the dynamics of the nongroup health insurance market and to assess the appropriateness of alternative sources of funding for the nongroup subsidy.

II. The commissioner shall request and health carriers shall supply information no later than April 1 of each year sufficient to report on the distribution of rating factors being applied to small employers. The commissioner's report shall summarize the rating factors utilized by health carriers in the preceding calendar year.

III. The commissioner shall request and health carriers shall supply information no later than April 1 of each year sufficient to report on the types of health coverage being purchased by individuals and employers by geographic area. The report shall include specific details regarding the type of coverage, including, but not limited to, co-pays, out-of-pocket maximums, network restrictions, and deductibles.

IV. The commissioner shall file the required reports by July 1 of each year with the senate president, the speaker of the house, the chairperson of the house commerce committee, and the chairperson of the senate insurance committee.

11 Preexisting Condition Exclusion Periods. Amend RSA 420-G:7, I(a) to read as follows:

(a) No preexisting condition exclusion shall extend beyond a period of [~~3~~] ***12*** consecutive months [~~while the person's health coverage is in force and during which the person incurred no medical treatment expenses in connection with the preexisting condition, or beyond 6 consecutive months while the person has been continuously covered and actively at work full-time, or beyond 12 months~~] after the effective date of the person's health coverage; and

12 Preexisting Condition Exclusion Periods. Amend RSA 420-G:7, II(a) to read as follows:

(a) No preexisting condition exclusion period shall extend beyond a period of [~~3~~] ***9*** consecutive months [~~ending while the individual's or covered person's health coverage is in force and during which the individual incurred no medical care treatment expenses in connection with the preexisting condition, or beyond 9 months following~~] ***after*** the effective date of the person's health coverage].

13 Repeal. RSA 420-G:4, I(e)(7) relative to increasing the premium rate, is repealed.

14 Repeal. RSA 420-G:4, III, relative to premium rates for certain large employers, is repealed.

15 Repeal. RSA 420-G:8, I(b), relative to medical underwriting, is repealed.

16 Effective Date.

I. Section 9 of this act shall take effect September 1, 2003.

II. Section 13 of this act shall take effect January 1, 2005.

III. Section 14 of this act shall take effect January 1, 2006.

IV. The remainder of this act shall take effect January 1, 2004.

2003-1692h

AMENDED ANALYSIS

This bill revises the laws relative to small group health insurance. The bill changes the definition of small group employer to employers with 2-50 employees. Current law defines small group employers to have 1-100 employees.

This bill also allows all private and public employers with at least 50 employees enrolled in their group health plan to receive health plan loss information upon request and without charge.

Rep. Hunt, Ches. 28
May 19, 2003
2003-1693h
09/10

Not Used

Amendment to SB 110

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IX-a. "Health coverage plan rate" means a rate that is uniquely determined for each of the coverages or health benefit plans a health carrier writes and that is derived from the base rate through the application of factors that reflect actuarially demonstrated differences in expected utilization or cost attributable to differences in the coverage design and/or the provider contracts that support the coverage.

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XII.(a) "Large employer" means an employer that employed on average at least [~~101~~] ***51*** persons, on business days, during the previous calendar year.

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(b) Base rate shall be established by each health carrier for all of its health coverages offered to individuals and, separately, for all of its health coverages offered to small employers.

(c) Health carriers shall calculate health coverage plan rates for each of the coverages or health benefit plans written by that carrier. Variations in health coverage plan rates shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

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(1) The maximum premium differential for age as determined by ratio shall be 4 to 1. The limitation shall not apply for determining rates for an attained age of less than 19.

(2) The maximum differential due to health status shall be 1.5 to 1 and the maximum differential rate due to tobacco use shall be 1.5 to 1. Rate limitations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(3) Permissible rating characteristics shall not include changes in health status after issue.

(e) In establishing the premium charged, health carriers providing coverage to small employers shall calculate a rate that is derived from the health coverage plan rate through the application of rating factors that the carrier chooses to utilize for age, group size, industry classification, geographic location, and health status. Such factors may be utilized only in accordance with the following limitations:

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(2) Carriers modifying such average premium for age may do so only by using the following age brackets:

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(3) Carriers may use group size as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 20 percent; provided that for groups of one, an additional 10 percent rating factor shall be allowed from the highest factor.

(4) Carriers may use the small employer group's industry classification as a rating factor. However, the highest factor based on industry classification shall not exceed the lowest factor based on industry classification by more than 20 percent.

(5) Carriers may use the small employer group's geographic location as a rating factor. However, the highest factor based on geographic location shall not exceed the lowest factor based on geographic location by more than 15 percent.

(6) Carriers may use the health status of the small employer group as a rating factor. However, the application of a health status factor shall be subject to the following limitations:

(A) The health status factor may reflect health status of covered persons, the small employer's claim experience, or the duration of coverage since health statements were last provided.

(B) Variations from the arithmetic average of the highest rate charged to the lowest rate charged shall not exceed 25 percent.

(C) Upon the renewal of a small employer policy, any increase in the premium rate that is solely attributable to changes in the health status factor from the prior year shall be no more than 15 percent.

(7) Upon the renewal of a small employer policy, a carrier is prohibited from increasing the premium rate by more than 25 percent of the rate that was charged in the preceding year. Such rate increase limitation shall not include any premium rate increase that is based on a carrier's annual cost and utilization trends or changes in the rating factor for attained age of covered persons.

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(g) The same rating methodology shall apply to newly covered individuals and to individuals renewing at each annual renewal date, or to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in

wellness and fitness programs provided such incentives are approved by the insurance department.

(h) The commissioner shall not approve any filing if such filing is excessive, inadequate or contrary to the intent of this chapter.

6 New Paragraph; Premium Rates. Amend RSA 420-G:4 by inserting after paragraph II the following new paragraph:

III. A health carrier, when determining the premium charged to a large employer group that employs from 51 to 100 employees, shall calculate the rate using a weighted average calculation consisting of the group's experience and the carrier's large employer group pool experience. The weight used for the group's experience shall be no more than 25 percent and the weight used for the experience of the carrier's large employer group pool shall be a minimum of 75 percent.

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420-G:5 Medical Underwriting.

I Health carriers providing health coverage for individuals or small employer groups may perform medical underwriting, including the use of health statements or screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4. Such underwriting may be limited to the use of a standardized health statement for use in adjustments to rating pursuant to RSA 420-G:4. The commissioner may, by rule, require carriers to use standardized health statements.

II. Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status. Regardless of claim experience, health status, or medical history, health carriers providing health coverage for small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

III. Health carriers providing health coverage for small employer groups shall not knowingly provide health coverage to groups where the employer has discriminated based on health status or claims history against any employee or potential employee or his or her dependents with respect to participation in an employer-sponsored health benefit plan.

IV. Health carriers shall not offer riders or endorsements to exclude certain illnesses or health conditions in order to avoid the purpose of this chapter.

V. Individual health insurance carriers shall be responsible for ascertaining the eligibility of any individual applicant or insured for high risk pool coverage. If a carrier determines that an individual meets any of the eligibility criteria set forth in RSA 404-G:5-e, the carrier shall give the individual written notice, with the declination of coverage, the coverage offering or upon a rate increase at renewal. The notice shall include information about available benefits and exclusions of high risk pool coverage and the name, address, and telephone number of the pool administrator or the administrator's designee.

VI. It shall constitute an unfair trade practice under RSA 417 for an insurer, insurance producer, or third party administrator to refer an individual employee to the pool, or arrange for an individual employee to apply to the pool, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

8 Qualified Association Trust. RSA 420-G:10 is repealed and reenacted to read as follows:

420-G:10 Qualified Association Trust.

I. A qualified association trust or other entity, as defined in RSA 420-G:2, XV, shall:

(a) Comply with the rating restrictions outlined in RSA 420-G:4 for all small employer members with 50 or fewer employees based upon the association's group experience, except that no rating factor shall be utilized without the express written consent of the association.

(b) Offer all eligible members, as defined under the applicable trust or other documents, coverage and rates on a guaranteed issue and renewable basis.

(c) Comply with the regulations concerning medical underwriting in RSA 420-G:5.

(d) Comply with the preexisting conditions provision of RSA 420-G:7.

II. Nothing in this chapter shall be interpreted to limit the size of employers who may participate in coverage with a qualified association trust.

9 Group Health Insurance; Health Plan Loss Information. RSA 420-G:12-a is repealed and reenacted to read as follows:

420-G:12-a Health Plan Loss Information.

I. To ensure maximum competition in the purchase of group health insurance, all private and public employers with at least 50 employees enrolled in their group health plan shall be entitled to receive their specific health plan loss information upon request and without charge. No contract between any health carrier, third-party administrator, employer group or pool of employers shall abridge this right in any manner.

II. Upon written request from any private or public employer with 50 or more employees enrolled in its group health plan, every health carrier, third-party administrator, pooled risk management program under RSA 5-B or any other type of multiple employer health plan shall provide that employer's loss information within 30 calendar days of receipt of the request. The loss information shall include all physician, hospital, prescription drug, and other covered medical claims specific to the employer's group plan incurred for the 12-month period paid through the 14 months which end within the 60-day period prior to the date of the request. An employer shall not be entitled by this section to more than 2 loss information requests in any 12-month period; however, nothing shall prohibit a carrier from fulfilling more frequent requests on a mutually agreed-upon basis.

III. If an employer requests loss information from an insurance agent or other authorized representative, including an administrator of a pooled risk management program or a multiple employer health plan, the agent or authorized representative shall transmit the request to the

health carrier or carriers or third-party administrator within 4 working days.

10 Commissioner's Requested Information. Amend RSA 420-G:14-a to read as follows:

420-G:14-a Requested Information.

I. As authorized in accordance with RSA 420-G:14, the commissioner may request the submission of such information by carriers as is necessary to better understand the coverage history and choices of participants in the nongroup market. The commissioner shall make every attempt to ensure the reasonableness of such request, both in terms of scope and timeframe, and to limit this request to information the commissioner deems necessary to better understand the dynamics of the nongroup health insurance market and to assess the appropriateness of alternative sources of funding for the nongroup subsidy.

II. The commissioner shall request and health carriers shall supply information no later than April 1 of each year sufficient to report on the distribution of rating factors being applied to small employers. The commissioner's report shall summarize the rating factors utilized by health carriers in the preceding calendar year.

III. The commissioner shall request and health carriers shall supply information no later than April 1 of each year sufficient to report on the types of health coverage being purchased by individuals and employers by geographic area. The report shall include specific details regarding the type of coverage, including, but not limited to, co-pays, out-of-pocket maximums, network restrictions, and deductibles.

IV. The commissioner shall file the required reports by July 1 of each year with the senate president, the speaker of the house, the chairperson of the house commerce committee, and the chairperson of the senate insurance committee.

11 Preexisting Condition Exclusion Periods. Amend RSA 420-G:7, I(a) to read as follows:

(a) No preexisting condition exclusion shall extend beyond a period of [~~3~~] ***12*** consecutive months [~~while the person's health coverage is in force and during which the person incurred no medical treatment expenses in connection with the preexisting condition, or beyond 6 consecutive months while the person has been continuously covered and actively at work full-time, or beyond 12 months~~] after the effective date of the person's health coverage; and

12 Preexisting Condition Exclusion Periods. Amend RSA 420-G:7, II(a) to read as follows:

(a) No preexisting condition exclusion period shall extend beyond a period of [~~3~~] ***9*** consecutive months [~~ending while the individual's or covered person's health coverage is in force and during which the individual incurred no medical care treatment expenses in connection with the preexisting condition, or beyond 9 months following~~] ***after*** the effective date of the person's health coverage.

13 Repeal. RSA 420-G:4, I(e)(7) relative to increasing the premium rate, is repealed.

14 Repeal. RSA 420-G:4, III, relative to premium rates for certain large employers, is repealed.

15 Repeal. RSA 420-G:8, I(b), relative to medical underwriting, is repealed.

16 Effective Date.

I. Section 9 of this act shall take effect September 1, 2003.

II. Section 13 of this act shall take effect January 1, 2005.

III. Section 14 of this act shall take effect January 1, 2006.

IV. The remainder of this act shall take effect January 1, 2004.

2003-1693h

AMENDED ANALYSIS

This bill revises the laws relative to small group health insurance. The bill changes the definition of small group employer to employers with 2-50 employees. Current law defines small group employers to have 1-100 employees.

This bill also allows all private and public employers with at least 50 employees enrolled in their group health plan to receive health plan loss information upon request and without charge.

Rep. Hunt, Ches. 28
May 20, 2003
2003-1713h
01/09

Amendment to SB 110

Amend the title of the bill by replacing it with the following:

AN ACT relative to small group health insurance coverage and relative to health plan loss information.

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

1 Definition; "Base Rate." RSA 420-G:2, I is repealed and reenacted to read as follows:

I. "Base rate" means a single rate reflecting the carrier's average cost of actual or anticipated claims for all health coverages or health benefit plans the carrier writes and maintains in a market, including the nongroup individual health insurance market and the small employer group health insurance market.

2 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph IX the following new paragraph:

IX-a. "Health coverage plan rate" means a rate that is uniquely determined for each of the coverages or health benefit plans a health carrier writes and that is derived from the base rate through the application of factors that reflect actuarially demonstrated differences in expected utilization or cost attributable to differences in the coverage design and/or the provider contracts that support the coverage.

3 Definition of Large Employer. Amend RSA 420-G:2, XII(a) to read as follows:

XII.(a) "Large employer" means an employer that employed on average at least [~~101~~] ***51*** persons, on business days, during the previous calendar year.

4 Definition of a Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to [~~100~~] ***50*** employees, including owners and self-employed persons, on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

5 Premium Rates for Small Employers. RSA 420-G:4, I is repealed and reenacted to read as follows:

I. Health carriers providing health coverage to individuals and small employers under this chapter shall be subject to the following:

(a) All premiums charged shall be guaranteed for at least 12 months, unless otherwise allowed by the commissioner.

(b) Base rate shall be established by each health carrier for all of its health coverages offered to individuals and, separately, for all of its health coverages offered to small employers.

(c) Health carriers shall calculate health coverage plan rates for each of the coverages or health benefit plans written by that carrier. Variations in health coverage plan rates shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

(d) In establishing the premium charged, health carriers providing coverage to individuals shall calculate a rate that is derived from the health coverage plan rate through the application of rating factors that the carrier chooses to utilize for age, health status, and tobacco use. Such factors may be utilized only in accordance with the following limitations:

(1) The maximum premium differential for age as determined by ratio shall be 4 to 1. The limitation shall not apply for determining rates for an attained age of less than 19.

(2) The maximum differential due to health status shall be 1.5 to 1 and the maximum differential rate due to tobacco use shall be 1.5 to 1. Rate limitations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(3) Permissible rating characteristics shall not include changes in health status after issue.

(e) In establishing the premium charged, health carriers providing coverage to small employers shall calculate a rate that is derived from the health coverage plan rate through the application of rating factors that the carrier chooses to utilize for age, group size, industry classification, geographic location, and health status. Such factors may be utilized only in accordance with the following limitations:

(1) Carriers may use the attained age of covered persons as a rating factor. However, the maximum premium differential for age as determined by ratio shall be 4 to 1 beginning with age 19.

(2) Carriers modifying such average premium for age may do so only by using the following age brackets:

0 - 18

19 - 24

25 - 29

30 - 34

35 - 39

40 - 44

45 - 49

50 - 54

55 - 59

60 - 64

65 +

(3) Carriers may use group size as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 20 percent; provided that for groups of one, an additional 10 percent rating factor shall be allowed from the highest factor.

(4) Carriers may use the small employer group's industry classification as a rating factor. However, the highest factor based on industry classification shall not exceed the lowest factor based on industry classification by more than 20 percent.

(5) Carriers may use the small employer group's geographic location as a rating factor. However, the highest factor based on geographic location shall not exceed the lowest factor based on geographic location by more than 15 percent.

(6) Carriers may use the health status of the small employer group as a rating factor. However, the application of a health status factor shall be subject to the following limitations:

(A) The health status factor may reflect health status of covered persons, the small employer's claim experience, or the duration of coverage since health statements were last provided.

(B) Variations from the arithmetic average of the highest rate charged to the lowest rate charged shall not exceed 25 percent.

(C) Upon the renewal of a small employer policy, any increase in the premium rate that is solely attributable to changes in the health status factor from the prior year shall be no more than 15 percent.

(7) Upon the renewal of a small employer policy, a carrier is prohibited from increasing the premium rate by more than 25 percent of the rate that was charged in the preceding year. Such rate increase limitation shall not include any premium rate increase that is based on a carrier's annual cost and utilization trends or changes in the rating factor for attained age of covered persons.

(f) Each rating factor that a carrier chooses to utilize shall be reflective of claim cost variations that correlate with that factor independently of claim cost variations that correlate with any of the other allowable factors.

(g) The same rating methodology shall apply to newly covered individuals and to individuals renewing at each annual renewal date, or to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be

construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

(h) The commissioner shall not approve any filing if such filing is excessive, inadequate or contrary to the intent of this chapter.

6 New Paragraph; Premium Rates. Amend RSA 420-G:4 by inserting after paragraph II the following new paragraph:

III. A health carrier, when determining the premium charged to a large employer group that employs from 51 to 100 employees, shall calculate the rate using a weighted average calculation consisting of the group's experience and the carrier's large employer group pool experience. The weight used for the group's experience shall be no more than 25 percent and the weight used for the experience of the carrier's large employer group pool shall be a minimum of 75 percent.

7 Medical Underwriting. RSA 420-G:5 is repealed and reenacted to read as follows:

420-G:5 Medical Underwriting.

I Health carriers providing health coverage for individuals or small employer groups may perform medical underwriting, including the use of health statements or screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4. Such underwriting shall be limited to the use of a standardized health statement for use in adjustments to rating pursuant to RSA 420-G:4. The commissioner shall, by rule, require carriers to use standardized health statements.

II. Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status. Regardless of claim experience, health status, or medical history, health carriers providing health coverage for small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

III. Health carriers providing health coverage for small employer groups shall not knowingly provide health coverage to groups where the employer has discriminated based on health status or claims history against any employee or potential employee or his or her dependents with respect to participation in an employer-sponsored health benefit plan.

IV. Health carriers shall not offer riders or endorsements to exclude certain illnesses or health conditions in order to avoid the purpose of this chapter.

V. Individual health insurance carriers shall be responsible for ascertaining the eligibility of any individual applicant or insured for high risk pool coverage. If a carrier determines that an individual meets any of the eligibility criteria set forth in RSA 404-G:5-e, the carrier shall give the individual written notice, with the declination of coverage, the coverage offering or upon a rate increase at renewal. The notice shall include information about available benefits and exclusions of high risk pool coverage and the name, address, and telephone number of the pool administrator or

the administrator's designee.

VI. It shall constitute an unfair trade practice under RSA 417 for an insurer, insurance producer, or third party administrator to refer an individual employee to the pool, or arrange for an individual employee to apply to the pool, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

8 Qualified Association Trust. RSA 420-G:10 is repealed and reenacted to read as follows:

420-G:10 Qualified Association Trust.

I. A qualified association trust or other entity, as defined in RSA 420-G:2, XV, shall:

(a) Comply with the rating restrictions outlined in RSA 420-G:4 for all small employer members with 50 or fewer employees based upon the association's group experience, except that no rating factor shall be utilized without the express written consent of the association.

(b) Offer all eligible members, as defined under the applicable trust or other documents, coverage and rates on a guaranteed issue and renewable basis.

(c) Comply with the regulations concerning medical underwriting in RSA 420-G:5.

(d) Comply with the preexisting conditions provision of RSA 420-G:7.

II. Nothing in this chapter shall be interpreted to limit the size of employers who may participate in coverage with a qualified association trust.

9 Group Health Insurance; Health Plan Loss Information. RSA 420-G:12-a is repealed and reenacted to read as follows:

420-G:12-a Health Plan Loss Information.

I. To ensure maximum competition in the purchase of group health insurance, all private and public employers with at least 50 employees enrolled in their group health plan shall be entitled to receive their specific health plan loss information upon request and without charge. No contract between any health carrier, third-party administrator, employer group or pool of employers shall abridge this right in any manner.

II. Upon written request from any private or public employer with 50 or more employees enrolled in its group health plan, every health carrier, third-party administrator, pooled risk management program under RSA 5-B or any other type of multiple employer health plan shall provide that employer's loss information within 30 calendar days of receipt of the request. The loss information shall include all physician, hospital, prescription drug, and other covered medical claims specific to the employer's group plan incurred for the 12-month period paid through the 14 months which end within the 60-day period prior to the date of the request. An employer shall not be entitled by this section to more than 2 loss information requests in any 12-month period; however, nothing shall prohibit a carrier from fulfilling more frequent requests on a mutually agreed-upon basis.

III. If an employer requests loss information from an insurance agent or other authorized representative, including an administrator of a pooled risk management program or a multiple

employer health plan, the agent or authorized representative shall transmit the request to the health carrier or carriers or third-party administrator within 4 working days.

10 Commissioner's Requested Information. Amend RSA 420-G:14-a to read as follows:

420-G:14-a Requested Information.

I. As authorized in accordance with RSA 420-G:14, the commissioner may request the submission of such information by carriers as is necessary to better understand the coverage history and choices of participants in the nongroup market. The commissioner shall make every attempt to ensure the reasonableness of such request, both in terms of scope and timeframe, and to limit this request to information the commissioner deems necessary to better understand the dynamics of the nongroup health insurance market and to assess the appropriateness of alternative sources of funding for the nongroup subsidy.

II. The commissioner shall request and health carriers shall supply information no later than April 1 of each year sufficient to report on the distribution of rating factors being applied to small employers. The commissioner's report shall summarize the rating factors utilized by health carriers in the preceding calendar year.

III. The commissioner shall request and health carriers shall supply information no later than April 1 of each year sufficient to report on the types of health coverage being purchased by individuals and employers by geographic area. The report shall include specific details regarding the type of coverage, including, but not limited to, co-pays, out-of-pocket maximums, network restrictions, and deductibles.

IV. The commissioner shall file the required reports by July 1 of each year with the senate president, the speaker of the house, the chairperson of the house commerce committee, and the chairperson of the senate insurance committee.

11 Preexisting Condition Exclusion Periods. Amend RSA 420-G:7, I(a) to read as follows:

(a) No preexisting condition exclusion shall extend beyond a period of [~~3~~] *9* consecutive months [~~while the person's health coverage is in force and during which the person incurred no medical treatment expenses in connection with the preexisting condition, or beyond 6 consecutive months while the person has been continuously covered and actively at work full-time, or beyond 12 months~~] after the effective date of the person's health coverage; and

12 Preexisting Condition Exclusion Periods. Amend RSA 420-G:7, II(a) to read as follows:

(a) No preexisting condition exclusion period shall extend beyond a period of [~~3~~] *9* consecutive months [~~ending while the individual's or covered person's health coverage is in force and during which the individual incurred no medical care treatment expenses in connection with the preexisting condition, or beyond 9 months following~~] ***after*** the effective date of the person's health coverage.

13 New Section; Legislative Oversight Committee Established. Amend RSA 420-G by inserting after section 14-b the following new section:

420-G:14-c Legislative Oversight Committee.

I. There is hereby established a joint legislative oversight committee on small group health insurance reform. The committee shall review the reports filed by the commissioner pursuant to RSA 420-G:14-a, monitor the small group health insurance market in the state, and monitor the effect of SB 110 of the 2003 legislative session. The committee shall make recommendations for any legislative changes the committee deems necessary. The committee shall include 3 members, of the house, appointed by the speaker of the house and 2 senators, appointed by the president of the senate.

II. The committee shall submit a written report of its findings and recommendations to the president of the senate, the speaker of the house of representatives, and the chairpersons of the house commerce committee and senate insurance committee on November 1 of each year.

14 Repeal. RSA 420-G:4, I(e)(7) relative to increasing the premium rate, is repealed.

15 Repeal. RSA 420-G:4, III, relative to premium rates for certain large employers, is repealed.

16 Repeal. RSA 420-G:8, I(b), relative to medical underwriting, is repealed.

17 Repeal. RSA 420-G:14-c, relative to a legislative oversight committee, is repealed.

18 Effective Date.

I. Section 9 of this act shall take effect September 1, 2003.

II. Section 14 of this act shall take effect January 1, 2005.

III. Section 15 of this act shall take effect January 1, 2006.

IV. Section 17 of this act shall take effect January 1, 2009.

V. The remainder of this act shall take effect January 1, 2004.

2003-1713h

AMENDED ANALYSIS

This bill revises the laws relative to small group health insurance. The bill changes the definition of small group employer to employers with 2-50 employees. Current law defines small group employers to have 1-100 employees. The bill establishes a legislative oversight committee on small group health insurance reform.

This bill also allows all private and public employers with at least 50 employees enrolled in their group health plan to receive health plan loss information upon request and without charge.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # SB 110 Date 4-23-03

Committee Commerce

** Please Print All Information **

Name	Address	Phone	Representing	(check one) Pro	Con
Curtis J. Barry	228-3300 x102		Retail Merchants Assoc. of NH	✓	
Harold Sullivan	93 Juniper St. Manch, N.H.	669-0032	NAIFA-NH	✓	
Marilyn Arey	75 Chestnut St Franklin, NH 03235		VNA of Franklin	✓	
Sen. Flanders			Dist. 7	✓	
Steve Carter	PO Box 1149 Sutton, NH				✓
Elizabeth Dunn	PO Box 120 Wilton NH 03086	603 654-2311	Savage Wood Products		✓
John Cahill			Northstar Marketing Inc.	✓	
Jim Betser	NHAHU			✓	
Rep Barbara C. French		MERR 34			✓
Paula Minnehan	125 Airport Rd Concord NH	225-0900	NHHA		X
Rep Bob Letourneau		Dist 77		✓	
William J. Cummings	21 Depot St. Merrimack NH		Cummings Ins. + Myself.	✓	
J Babcock Keach - Nordstrom	10 Commerce Park No Ste 3B Bedford NH 03110	627-2881		✓	
Crescentia True	36 Wiswall Rd Durham		self		✓
Rep Tom Tucker	Merr. Dist 32			✓	
Rep Cliff Newton	Dist 67			✓	
L. William Davis	39 Bald Hill Rd Hoo	603-746-5664	Ins Broker		✓
Kipp Cooper	113A Airport R		NH Realtors	✓	

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON SB 110

BILL TITLE: relative to small group health insurance coverage.

DATE: April 23, 2003

LOB ROOM: 302 **Time Public Hearing Called to Order:** 1:15 pm

Time Adjourned: 5:10 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: Sens. Prescott, Clegg, Eaton, Flanders, Morse, R. Johnson, M. Carter and Reps. Letourneau and R. Wheeler

TESTIMONY

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

Gov. Craig Benson – Spoke in support of the bill. Expressed his concern with the high cost of insurance, and the lack of flexibility and choice. New Hampshire has the second highest state cost in the nation. We need to reduce costs and increase flexibility and choice.

Sen. Russell Prescott, prime sponsor – Introduced the bill. Recent reforms solved some problems and created others. With nine years perspective, we can see that community rating has caused an explosion in premium costs. This bill is a logical modification of the previous reforms. It guarantees access to insurance while providing rating variables to entice insurers back into the market. Increased competition will reduce cost and increase product choice. At least four insurers have stated that they will return to the state if SB 110 is passed. This bill, if passed, will cap rate increases at 25% for the next two years.

***Sen. Robert Clegg, co-sponsor** – In support of the bill. Voted a change in the bill that insures groups of one will still be eligible for small group coverage. The primary opposition to this bill comes from ANTHEM who controls 65% of the local market share. See written testimony.

***Rep. Mark Carter, co-sponsor** – The current rating system is too socialistic and overly regulates the setting of premiums. In 1994 New Hampshire had the 3rd lowest rates in the nation. Today, we have become one of the most costly states. This is a result of the community rating system and the resultant lack of competition. See written testimony.

Q: Rep. Rip Holden – Is this bill an effort to get back at ANTHEM for having a dominant market share?

A: That may be the result, but it was not the intent.

***Rep. Paul Harrington** – Supports the bill. See written testimony.

Sen. Clifton Below – Speaking in opposition to the bill. This bill is a step backwards and not forwards. The only thing this bill does is allow insurers to manage their risk exposure. It does nothing to reduce costs or improve access. For every winner, there will be a loser. This is a zero sum game. Some groups will receive benefits (i.e. lower premiums); others will face higher costs and/or reduced benefits. There are underlying cost drivers that are not addressed in this bill. With a renewed emphasis on rating, employers will have a direct economic consequence from their employment decisions. It would be hard not to discriminate. Many of the cost problems we experience are of our own making.

Q: Rep. Matthew Quandt – If we pass this bill, are rates in the seacoast likely to go up?

A: Yes, I am led to believe that because there is a higher level of risk in that geographic that they will experience higher premiums.

Sen. Burt Cohen – Speaking in opposition to the bill. There is no guarantee that increased competition will reduce costs. On the contrary, it is only likely to shift costs. While some will gain, other groups may see premiums increase 65% to 70% over the next two years.

Q: Rep. John Hunt – We have age banding now. Do you have any specific evidence that the current system is discriminatory?

A: No, but this bill will increase upward pressure on premium rates for the older population.

Rep. Ned Densmore – Opposed to the bill. Urged the committee to move cautiously. This bill has the potential to encourage age discrimination based on the differentiated cost of coverage. The North Country runs the risk of picking up the tab for cost shifts. The real problem with rising costs is the state's failure to address the true costs of Medicaid/Medicare.

Paula Rogers, Commissioner, NH Insurance Dept. – They take no position on the bill. The department has worked hard to make sure the bill does what its sponsors want. Our job is to analyze the bill and predict the outcomes are passed. Our analysis will demonstrate the pros and cons of passage of the bill. Private employers must pick up the shortfall in costs for Medicaid/Medicare and the uninsured.

***Alex Feldvebel, NH Insurance Dept.** – Passed out an analysis prepared by the department. See attached.

Q: Rep. Stephen DeStefano – If the state paid a higher level of reimbursement to Medicaid/Medicare, wouldn't that have a greater impact than this reform?

A: There is no easy answer, but cost shifting is a factor.

***Leslie Leduc, NH Insurance Dept.** – Passed out a document entitled "Supplemental Report of 2001 Health Insurance Market" and a fact sheet. The average premium cost in the small group market is comparable to the large group market. New Hampshire is a highly concentrated market. Small states tend to be highly concentrated. On a national basis, premium costs tend to be highly concentrated around a mean.

Sen. Gary Francoeur – Spoke in favor of the bill. We have come a long way in the past two years. We have better information to work with.

Mike Kellen, Fortis Health – Largest underwriter in the country for small groups, and short term policies. If SB 110 is passed, Fortis will return to the small group market. If SB 110 is passed, it will encourage more price competition and more coverage choice and innovation.

Q: Rep. Charles Clark – Questioned adding risk pool to SB 110.

***Sean Lynch, John Alden Insurance** - Favors the bill. Has written testimony. Will return to the market if SB 110 is passed.

***Elizabeth Dunn, Souhegan Wood Products, Inc.** – Spoke in opposition to the bill. See written testimony.

***Angela Franklin, Health Insurance Association of America** – Supports the bill. See written testimony.

***Mary Atwood, Lukas Learning Center** – Opposes the bill. While the purpose of the bill is well intentioned, the results will be detrimental to the small group insured. The legislation will not change the underlying costs of healthcare. The providers and utilization are driving costs. The only way insurers can impact costs is to reduce their risk. This is all about bidding for reduced risk.

***Beth Roberts, Harvard Pilgrim Healthcare** – Supports the bill with modification. See attached written testimony.

Bill Davis, representing self – Opposes the bill.

***Crescentia True, representing self** – Opposed to the bill. See written testimony.
We project that 70% of businesses will pay less and 30% will pay more. Fortis does not intend to use a geographic rating factor. This will make it more competitive in smaller markets. Compared health insurance to property insurance. Supports the bill. Group of one gets a slight advantage because of possible employer vis-à-vis employee incentive.

***Ronald Becker, ANTHEM Health Plans** – Don't think it will provide competitive market. The issue will cause uninsured elderly market. Competition on risk selection not rates. There would be higher competition in the younger markets and less in elderly markets. Ages at 3 to 1 should be greater at almost 4 to 1 – under 55, 3 ¼ less, over 60 increase of 13%, over 65 29% increase. Health cost highly skewed-other states have cherry picking-use risk adjusters. Connecticut has 28 companies with risk pool. The problem with SB 110 is ANTHEM has 90% of elderly pool. Radical shift and cost shifting seeking lower ages and healthier people. Willing to compete if pricing is fair. Too many carriers try to skim the market. They are disadvantaged by their high percentage of sick and elderly. Connecticut has high risk pool which works very well.

Q: Rep. Holden - ??? shows Connecticut has the highest rates in the nation.

Q: Rep. Mark Brady – Questioned loss of market share.

A: Yes they will.

***Gene Scribner, NH High Technology Council & C.I.M. Industries, Inc.** – Supports the bill. See written testimony.

Greta Cocco, First Benefits – Opposed to the bill. SB 110 is virtually the same as SB 119 several years ago. It is too aggressive. It goes too far too fast. The state just addressed the individual market in New Hampshire. We need time to analyze what is going on in the market. Today is the

first time we have had comprehensive data about what is going on in the state with varying group size.

Don Curry, CIGNA- Supports the bill.

*Margaret McClellen, Berlin Area Health Consortium – Opposed to the bill. See written testimony.

Bob Nash, IIABNH – Supports the bill.

*Dick Stonner, NFIB & Sir Speedy Printing – Supports the bill. Presented information on cost of insurance to his company. See written testimony.

* Clyde Terry, Granite State Independent Living - Opposed to the bill. See written testimony.

*Tom Boucher, NH Lodging and restaurant Association – Supports the bill. See attached written testimony.

Linda Millman, representing self – Opposed to the bill.

*Bill Carr, NH Business Council – Supports the bill. See written testimony.

*Bob Cranage, Morrill Corporation – Opposed to the bill. See written testimony.

*Dean Ogelby, NH Association of Insurance & Financial Advisors – Supports the bill. See written testimony.

*Kenneth Chapman, representing self – Opposed to the bill. Small business owner.

Respectfully Submitted:

Paul D. Spiess, Clerk

Sub-Committee Minutes

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON SB 110

BILL TITLE: relative to small group health insurance coverage.

DATE: April 30, 2003

Subcommittee Members: Reps. Hunt, Fraser, Francoeur, Clark, Brady, Flanders, Holden, Kopka, Meader, Quandt, Scamman, Spiess and Taylor

Comments and Recommendations: Reviewed the bill's definition. Written testimony submitted from Souhegan Wood Products from Randy Dunn and Eleizabeth Dunn.

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. John B. Hunt
Subcommittee Chairman/Clerk

Submitted for
4-30-03
Subcommittee
Work Session

SOUHEGAN WOOD PRODUCTS, INC.

Ten Souhegan Street P.O. Box 120 Wilton, New Hampshire 03086 USA Tel. (603) 654-2311 FAX (603) 654-6631

April 28, 2003

Representative John B. Hunt, Chairman
House Commerce Committee
Room 302, LOB
Concord NH 03301

RE SB110 An Act Relative to Small Group Health Insurance - IN OPPOSITION

Dear Chairman Hunt,

We fear that the proposed changes in small group health insurance will jeopardize our ability to continue health insurance benefits for our employees. With that concern in mind, we want to make the following two suggestions for the Commerce Committee to consider at its working session on Wednesday, April 30.

1) Eliminate provision for medical underwriting from the bill because it is :
   * the most expensive & time consuming to implement administratively
   * the most prone to data error in transmittal & evaluation of health records
   * impossible for employer to verfiy for accuracy unless the bill is amended to include annual loss runs for employers to check, as is the case with other insurance like workers compensation etc.

2) Change just one underwriting variable at a time. As any scientist knows, the only way to test the effect of any given variable is to change one at a time while holding other variables constant. If all of the 6 new underwriting rules in SB110 are introduced in one year and things go wrong, as some surely will, there will be no way to sort out which one(s) of the 6 caused the trouble. This will lead to many explanations by the champions of various issues but with no hard data to support any of them. If SB110 is being proposed as a way to improve the small group market, then it seems unwise to change multiple variables in one year. We believe that your job of mediating between the competing interests of consumers and insurance industry will be best served by testing any or all of the proposed changes gradually each year in order to find the right mix. SB110 is too much change too quickly!

Thank you for your consideration of our testimony last week and this follow-up letter.

Sincerely,

Randy Dunn

Randolph Dunn, President

Betsy Dunn

Elizabeth Dunn, VP

cc to all members of House Commerce Committee

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON SB 110

BILL TITLE: relative to small group health insurance coverage.

DATE: May 6, 2003

Subcommittee Members: Reps. Hunt, Fraser, Brady, Taylor, Spiess, Kopka, Clark, Meader, Quandt, Scamman, Spiess, and Stepanek

Comments and Recommendations: Review rating factors.

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. John B. Hunt
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON SB 110

BILL TITLE: relative to small group health insurance coverage.

DATE: May 13, 2003

Subcommittee Members: Reps. Hunt, Fraser, Spiess, Brady and Taylor

Comments and Recommendations: No Notes

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. John B. Hunt
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON SB 110

BILL TITLE: relative to small group health insurance coverage.

DATE: May 15, 2003

Subcommittee Members: Reps. Hunt, Fraser, Brady, Taylor, Spiess

Comments and Recommendations: Review amendment.

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. John B. Hunt
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON SB 110

BILL TITLE: relative to small group health insurance coverage.

DATE: May 20, 2003

Subcommittee Members: Reps. Hunt, Taylor, Brady, Spiess, Fraser, Kopka

Comments and Recommendations: No notes.

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. John B. Hunt
Subcommittee Chairman/Clerk

Testimony

PO Box 25
Lincoln, NH 03251
Phone: 603-745-8527
Fax: 603-745-6743

Town of Lincoln

Fax

To:	Commerce Committee Chairman John B. Hunt	**From:**	Deanna Huot, Chair, Lincoln Selectmen
Fax:	Legislative Office Bldg. Room 302 271-6689	**Date:**	4/22/03
Phone:		**Pages:**	1 to follow
Re:		**CC:**	

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

We respectfully request that the attached be entered into the record at the Commerce Committee's Hearing on SB 110.

Thank you.

Town of Lincoln

LINCOLN, N.H. 03251 603-745-2757 FAX 745-6743

SELECTMEN'S OFFICE

Deanna Huot Peter Moore Patricia McTeague

MEMO

TO: The Honorable John B. Hunt
Chairman, Commerce Committee
FROM: Lincoln Board of Selectmen
RE: Senate Bill 110
DATE: April 21, 2003

PLEASE HAVE THE FOLLOWING READ FOR THE RECORD AT THE 4/23/03 HEARING:

The Lincoln Board of Selectmen would like to go on record as opposing Senate Bill 110.

After studying the provisions of the bill, we believe it will have a detrimental impact on the residents of the North Country, where tourism is the main industry. Many of our residents in this part of the state are underinsured or uninsured, and we fear if this bill is passed, those numbers will increase. The long-term effect of such a scenario would be ever higher medical costs for everyone.

Please share this memo with your fellow committee members and ask them to do whatever possible to prevent passage of this proposed legislation.

Deanna S. Huot
Chairman Deanna Huot

genesis
Behavioral Health

April 18, 2003

To: Members of the NH House Commerce Committee

I am writing to express my concern regarding Senate Bill 110. I serve as the executive director of Genesis Behavioral Health, the community mental health center that serves Belknap and southern Grafton counties through offices in Laconia and Plymouth. As an employer, I welcome attempts to expand the choice of health care providers in our state. Our organization has essentially had two choices to address the health care needs of our employees: 1) Anthem; 2) become self-insured. Cigna remains non-competitive and there really are no other choices. While we applaud the intent of Senate Bill 110, we believe that the price for choice may be too high for organizations like ours.

Genesis is a non-profit private employer. We contract with the NH Division of Behavioral Health each year to provide mental health services to the most vulnerable residents in the area we serve. Approximately 90 Genesis employees are eligible for insurance. If SB 110 passes, we will shift from the small employer to large employer category and our rates will be based on our employees' health experience. In an organization our size, even a few serious illnesses can have a dramatic impact on our experience. We have had those illnesses. However, we have been able to maintain our insurance coverage because of the community rating process. We are deeply concerned that should we shift to an experience rated system, we would incur a very sharp increase in our current rates. After absorbing rate increases of 13% and 25% in consecutive renewals, we are deeply concerned about the impact of another sharp rate increase on our operation. We anticipate an 18% increase this year. With anticipated funding cuts from the Division, another sharp increase in our medical premiums could be crippling.

To compound the issue, because we are currently deemed a small employer, we cannot obtain our experience information from our insurer. Repeated requests for this information have been denied because the insurer is not compelled to provide that information to a small employer. Thus, we are unable to assess the potential impact of this change on our agency until it is too late.

I ask that you oppose this bill when it comes to a vote. The reality of SB110 is that it will provide short term benefits to the larger employers in the state while the insurers recoup their looses through the increased premiums to the newly created "large employers."

Thank you for your time and consideration.

Sincerely,

Michael Coughlin

Michael Coughlin
Executive Director

111 Church Street • Laconia NH 03246 • Tel 603/524-1100 • Fax 603/528-0760 • www.genesisbh.org

RESPECT WORK STRENGTHEN FAMILY
AFL-CIO

NEW HAMPSHIRE AFL-CIO

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161 LONDONDERRY TURNPIKE
HOOKSETT, NH 03106
PHONE: 603-623-7302
FAX: 603-623-7304
E-MAIL: NHAFLCIO@compuserve.com
www.nhaflcio.org

SB 110 Is the Wrong Direction for NH Health Care Policy
A Statement by Mark MacKenzie
April 23, 2003

On behalf of more than 40,000 New Hampshire AFL-CIO members, I urge members of the House Commerce Committee to vote SB 110 Inexpedient to Legislate.

Our nation's employer-based health insurance system is in crisis. Soaring insurance costs are gobbling up wage increases. Premium hikes and cost shifting are swelling the ranks of the insured. Families without health coverage are turning to emergency rooms for their health care needs. And our hospitals are facing growing demands for uncompensated care.

We face difficult choices. But by moving away from community rating and redefining small groups, SB 110 takes us in the wrong direction. Allowing rate hikes based on health status, business classification, or geography will put more pressure on small employers and reduce access to affordable health care. Permitting open-ended underwriting hikes for employers with more than 50 workers will compound this problem.

Creating barriers to affordable care is a problem that affects us all. While the uninsured delay medical treatment, they are more likely to require more expensive care when they do seek treatment – often at an emergency room.

SB 110 will make health coverage less affordable for small employers with older workers, employees with health problems, and with facilities in the North Country or on the Seacoast. That's bad for our state's economy.

Economic development for the North Country is a major challenge. Forcing small employers to pay more for insurance, to shift costs to employees, or to drop health insurance compounds that problem.

Some argue that SB 110 will attract additional insurers to New Hampshire and increase competition. I am skeptical that will happen, but if it does, it will take the form of encouraging insurers to cherrypick younger, healthier workers who are less likely to seek treatment. That will increase pressure on our health care system as a whole.

Thank you for your consideration.

To: John Hunt
Commerce Committee Room 302

From: Karen Rallis
20 Morrill St.
Hampton, N.H.
03842
(603) 926-9306

April 22,2003

Dear John,

I will be unable to attend the Senate Hearing on Senate Bill 110 on April 23,2003. I have been informed that the letters that I am faxing to you will be read at the hearing and become part of the permanent record. It is very important to me that these letters are read and I appreciate your acceptance of them. If there is any problem in getting the information heard at this hearing, please call me as soon as possible.

Thank-you,

Karen Rallis

To: John Hunt
Commerce Committee Room 302

Re: Senate Bill 110

I am adamantly opposed to the passage of Senate Bill 110. This bill places all people who buy their own health insurance at risk for having no health insurance coverage. Every family has the potential for having a member become seriously ill. If we allow the insurance carriers to decide who should be denied coverage in a family plan we will be taking health insurance from those who need it most.

Sincerely,
Jean Acton , Manchester, N.H.

To: John Hunt
Commerce Committee Room 302

Re: Senate Bill 110

I would like to voice my opposition to Senate Bill 110. Under section 420-G:5 MEDICAL UNDERWRITING , insurance carriers will be allowed to discriminate against individuals who need health insurance most. This would result in many individuals not being able to afford health insurance and not receiving the health care that they need. By segregating "high risk" individuals into a separate pool or allowing the insurance company to raise their premiums up to 25% per year , those who need insurance most would be unable to afford their insurance bill.

Every family has the potential to have a family member with a serious illness. If we allow the insurance companies the freedom to discriminate against our family members, history shows they will take advantage of this.

Included in this bill is the opportunity for insurance carriers to raise annual premiums up to 25% or deny or limit coverage to those they determine to be high risk. A self-employed family of four buying their own health insurance and paying $850.00 per month for HMO coverage would see their premiums rise to $1062.50 per month the first year. This would be an annual cost of $12,750.00 . The second year they would pay $15,937.50. The third year they would pay $19,921.88. By the fifth year this same family of four would have an annual premium of $31,127.94 to keep their same coverage. People could lose their homes trying to keep health insurance. This bill could be disastrous to many NH families.

Every family has the potential of having someone becoming seriously ill, so this bill essentially places all families at risk.
PLEASE DO NOT PASS SENATE BILL 110.

Sincerely,

Karen Rallis , Hampton N.H.

To: John Hunt
Commerce Committee Room 302

Re: Senate Bill 110

I oppose Senate Bill 110. The purpose of the insurance industry is to provide coverage for individuals when they are healthy and when they are not. By passing this bill you allow insurance carriers to decide who they will offer affordable health insurance to and who they will not. Do we really want to hand over the individual's right to health care to the insurance industry?

Sincerely,
Mary McCarthy
3 Heritage Dr.
Hampton N.H.

Trustmark

INSURANCE COMPANY

M. Ray Haase
Senior Vice President
Health Insurance

400 Field Drive • Lake Forest, Illinois 60045
Phone (847) 283-3000 • Fax (847) 615-5860
Email: rhaase@trustmarkins.com

Starmark Small Group
MultiBenefit Services, Inc.

April 16, 2003

The Honorable John B. Hunt, Chair
House Commerce Committee
House of Representatives
Room 302 LOB
Concord, NH 03301

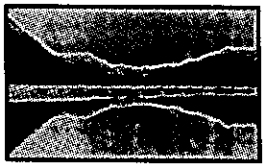
Dear Mr. Hunt:

I am the CEO of Starmark, the small group insurance subsidiary of Trustmark Insurance Company. New Hampshire will be a viable small group market for health insurance if senate bill 110 is enacted. This bill gives protection to both the consumer and the insurance carrier and is much more in line with most other states which have modeled their small group reform based on the NAIC model. Trustmark will plan to come back into the market if senate bill 110 is passed.

Sincerely,

Ray Haase

Ray Haase
CEO & President, Starmark
Trustmark Insurance Company



LRGHealthcare

Care. Compassion. Community.

New Hampshire Business of the Decade in Healthcare

April 21, 2003

Honorable John Hunt
Chairman, House Commerce Committee
State House
Concord, NH 03301

RE: Support of SB 110

Dear Representative Hunt:

On behalf of Lakes Region General Hospital and Franklin Hospital, I am writing in support of Senate Bill 110. We believe the enactment of this legislation will improve access to health care in New Hampshire, especially rural areas, and will result in greater insurance choice for the small business community.

Like many other health care organizations, LRGHealthcare supported the insurance reforms enacted in 1994. In theory, we believed these policies would stabilize health insurance costs and improve access in rural areas of the state. While we continue to believe that guaranteed issue and renewability of insurance are beneficial, it is now clear that community rating and other unique laws, such as defining the small group market as 1-100, have been a burden on the state.

The problems created by these policies include:

Community rating creates upward pressure on the state's uninsured rate. This policy forces populations most at risk of being uninsured (young, less affluent citizens) to financially subsidize insurance coverage for older, more affluent citizens. This policy increases the cost of insurance for these vulnerable groups, and makes the purchase of insurance more difficult for them. Studies on the effects of community rating on insurance coverage point out that this policy leads to lower levels of insurance coverage, and offset any gains made by enacting guaranteed issue and renewability laws[1]. Claims that community rating laws are responsible high rates of insurance coverage in New Hampshire are not supported by research on the issue, and, in fact, past studies by the NH Department of Insurance make it clear that community rating is not a factor in state's high rate of insurance coverage[2].

[1] Jill Marsteller, Len Nichols, Adam Badawi et al, *Variations in Recent State Small Employer Health Insurance Reforms* (Washington, DC: Urban Institute, June 1998).
[2] James Lee, Nancy McCall, Chuan Fen Liu et al, *An Investigation Into the Effects of the New Hampshire Health Insurance Reform Law, RSA 420-G* (Waltham, MA, Center for Health Economics Research, 1997)

Community rating creates disincentives for citizens to maintain healthy lifestyles. New Hampshire's current law provides subsidies for many citizens who maintain unhealthy lifestyles or habits, such as smoking. Instituting appropriate, limited health rating bands, as recommended by the National Association of Insurance Commissioners, will provide financial incentives for citizens to maintain healthy lifestyles, provide an opportunity to attract new lives into the insurance market and will keep premiums affordable for people with chronic conditions by limiting the ability to rate for health status.

Community rating has caused the deterioration of the insurance market and eliminated access to lower cost insurance products. As was predicted by many insurance experts, the enactment of community rating has resulted in many insurance companies exiting the New Hampshire market and has severely limited employers' access to lower cost insurance products. The ability for insurers to only offer products in particular areas of the state has made these negative effects have been more pronounced in rural areas of the state. This has placed increase financial pressures on employers and threatens access to coverage for employees. Encouraging the establishment of new insurance products, not based on the need for high patient volumes, should increase availability and access to health insurance in rural areas.

By enacting SB 110 and encouraging insurance companies to return to the state, we believe New Hampshire will begin to reverse the many negative consequences of community rating and other unique small group insurance laws. LRGHealthcare looks forward to the opportunity to work with new insurers to spur product innovation and improve access to the health care system in rural areas of New Hampshire.

Thank you for your consideration of this letter, and we encourage you to support the passage of SB 110.

Sincerely,

Thomas Clairmont
President & CEO

cc: House Commerce Committee
Speaker Gene Chandler
Senator Bob Flanders
NH Hospital Association

SOUHEGAN WOOD PRODUCTS, INC.

Ten Souhegan Street P.O. Box 120 Wilton, New Hampshire 03086 USA Tel. (603) 654-2311 FAX (603) 654-6631

May 9, 2003

Representative John B. Hunt, Chairman
House Commerce Committee
Room 302. LOB
Concord NH 03301

RE SB110 An Act Relative to Small Group Health Insurance - IN OPPOSITION

Dear Chairman Hunt,

I wish I shared your optimism about the benefits of the proposed changes to the small group health insurance market. My experience tells me that much of SB110 is flawed.

I want, however, to follow up on our conversation after the Committee meeting last Tuesday. Since privacy considerations preclude annual loss runs for each employer to verify, I have an alternative suggestion.

Instead of a consolidated loss run to the employer, each employee would receive their own individual loss run for the prior year for verification and then give their employer a signed statement of accuracy or of the error(s) if that is the case. This serves both goals of privacy and verfication. I know that the insurance industry will complain about cost but it is trivial by comparison with the costs of medical underwriting about which they have been silent. With the data already in the computers the annual loss run to each employee is no more than for paper and postage.

There were many people at the Hearing who expressed serious concerns about SB110 *I hope that the Committee is giving them equal weight in their considerations.*

Sincerely,

Betsy Dunn

Elizabeth Dunn
Vice President

NEW HAMPSHIRE LODGING & RESTAURANT ASSOCIATION

PO Box 1175 · 14 Dixon Avenue · Suite 208 · Concord, NH 03302-1175
(603) 228-9585 · Fax (603) 226-1829 · Email: nhlra@nhlra.com · Website: www.nhlra.com

April 23, 2003

Representative John Hunt, Chairman
House Commerce Committee
Room 302, LOB
Concord, NH 03301

Dear Chairman Hunt:

Good Afternoon. My name is Tom Boucher. I am one of the owners of CJ's and T-Bones Restaurants, which are located in Hudson, Bedford, Salem and Manchester. I also chair the Government Affairs Committee of the New Hampshire Lodging & Restaurant Association. I am here this afternoon on behalf of the Association and its 700 plus members across the State to speak in favor of Senate Bill 110.

One of the biggest complaints we hear from our members is the cost of health insurance. It is the fastest growing cost for many small businesses. There are very few things we can do to have an impact on these costs beyond simply passing more and more of them on to employees.

The reason our Association is here this afternoon is because we believe SB 110 will provide us more choices and a greater ability to control the cost of providing health insurance to our employees. We have no expectation that SB 110 will be the silver bullet to solve all the problems with the cost of healthcare, but we do believe that by increasing competition and inviting a broader array of health insurance products to be offered to small businesses, that we'll at least be afforded a better opportunity to pick and choose insurance products that suit our own particular circumstances.

The current insurance market for small businesses in New Hampshire clearly is not working. We're rated one of the healthiest states but have the second highest family coverage health insurance rates for small business in the country. In addition to high cost, there are very few choices. The rules for insurers need to be changed. We need more choices and lower prices. We simply cannot continue down the road we are on today.

On behalf of the New Hampshire Lodging & Restaurant Association, we ask you to give favorable consideration to SB 110.

Sincerely,

T. Boucher

Thomas C. Boucher
Vice Chairman Restaurants
Governmental Affairs Chairperson

NATIONAL RESTAURANT ASSOCIATION
AMERICA'S PROMISE
American Hotel & Lodging Association

PRESIDENT
Sean O'Kane
Holiday Inn/Center of NH

VICE PRESIDENT • LODGING
Nick Pancoast
Holiday Inn Concord

VICE PRESIDENT • RESTAURANTS
Thomas Boucher
T-Bones/Cactus Jacks

VICE PRESIDENT • ALLIED
Mary Jo Boisvert
Public Service of NH

SECRETARY/TREASURER
Kevin P. Sullivan
Galley Hatch Catering

IMMED. PAST PRESIDENT
Robert Greenleaf, Jr.
Gateway Family Restaurants

EXECUTIVE DIRECTOR
Paul Hartgen
phartgen@nhlra.com

Rep. Paul Harrington

3 Brinton Drive
Nashua, NH. 03064
1-800-617-3001
FAX 603-882-4961
sunkingint@cs.com

April 23, 2003

Thank you Mr. Chairman & Honorable members of this Committee

I am here in Support of SB110.

As many of you know small businesses are the backbone of our state and our country. The small business community of New Hampshire represents nearly 98% of all the businesses in the State. Health Insurance has become a major expense to small businesses here due to the so-called health care reforms of the mid-1990's. It is shocking to see our state, with a population of just over 1.1 million people, currently has the second highest average family coverage health insurance rates for small businesses in the entire country.

My wife and I are owners of a small business and we have seen the rapid rise in health insurance rates in the past five or six years. Before you could choose a family policy for approx. $370 per month, now even a Medical Savings Health Insurance Policy is over $500 per

month with a $4000 deductable.

Please vote for OUGHT TO PASS on SB110 so we can pass this in the House and send it onto Gov. Benson to sign this into law.

Thank you for your time.

Rep. Paul Harrington

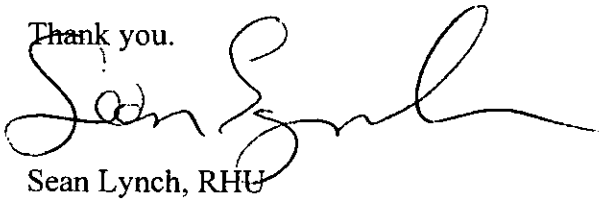
Testimony of
Sean Lynch of John Alden Insurance
on SB 110

On behalf of John Alden Insurance, I am pleased to offer our support for Senate Bill 110. We are confident that the reforms contained in SB 110 will benefit small business in New Hampshire by allowing insurance carriers to offer more insurance products and competitively price those products in your market.

John Alden Insurance is a licensed company in New Hampshire, however, we have significantly scaled back our efforts here due to the enactment of atypical state laws, such as defining small group as 1-100. While we offer many cutting edge products, such as medical savings account plans, around the country, we do not offer those types of products in New Hampshire due to your small group laws.

Given our status as a licensed company, I believe we can begin marketing our products here quickly upon enactment of this legislation. Our company made a similar commitment to you regarding the individual market reforms recently enacted, and we did return to the state. If small group reforms are enacted, we look forward to returning to that market with a full range of competitively priced insurance products.

Thank you.



Sean Lynch, RHU

John Alden Health Insurance

SB 110

- Senate leadership supports SB 110 and the need to reform the state's small group market.

- The Senate reviewed this bill carefully and did make amendments, most notably the change that allows sole proprietors to purchase group insurance and preserves the commitment from carriers to return to NH.

- The only opposition the Senate heard regarding the bill was generated by Anthem Blue Cross and Blue Shield, and I anticipate that you will be recipient of letters generated by them also.

- While Anthem was telling the NH small business community that SB 110 is a radical bill, they were supporting these same changes in Colorado. Another community rated state.

- Only last month, when testifying on HB 1164 and on an amendment to SB 162 in Colorado, Anthem testified that the long-term solution to the problems created in that state by community rating was enacting rate bands, like SB 110.

- Anthem's real opposition is to the threat to their market share. I would suggest that the only difference between New Hampshire and Colorado is that Anthem controls between 50-60% of the market here, and only 6% in Colorado.

- Anthem has no incentive to make any changes to the New Hampshire market, especially changes that would bring new competition to the state. They control the market and are making a lot of money.

- Thank you and I would encourage your support of this important bill.

Bill Carr
New Hampshire Business Council
Testimony on
SB 110

Good afternoon, my name is Bill Carr, President of the New Hampshire Business Council, and I appear in support of SB 110. The New Hampshire Business Council represents 75 for-profit businesses in the state, from a small 2-person convenience store to a company with in excess of $3 billion dollars of sales annually and over 27,000 employees worldwide. Our membership covers all facets of the business spectrum from manufacturing, wholesale, distribution, retail, and services. Our focus is to provide a unifying business community voice in support of activities that lead to a continuously expanding economic climate, a fair and balanced tax structure, and an enhanced quality of life for the citizens of New Hampshire.

While our organization focuses on many business issues, the problems associated with health insurance in New Hampshire is the issue we hear the most about from our members. Year after year, the small business community has had to deal with a small group insurance market that has had fewer and fewer companies, less and less product choice and escalating premium costs.

Not only have we seen our small group market deteriorate, but also New Hampshire's small business community is missing out on many innovative insurance products. Insurance products, such as Medical Savings Accounts plans or Health Reimbursement Arrangements, have either never come to New Hampshire or they are priced not to sell because of our laws. Without access to the lower cost or tax-deferred options found in some 38 other states, the New Hampshire small business community, over 33,000 strong, representing nearly 98% of all the businesses in the State, and over 62% of the private sector workforce, is put at a competitive disadvantage.

As you know, this is not an easy problem to solve. While I am not an insurance expert, I can see that if the situation does not change, and soon, the problem will only get worse. Without change, I predict that more businesses will be dropping health insurance coverage, or shifting an ever-greater portion of the cost burden onto employees. There will be more efforts by small businesses to escape the State's regulated insurance market through other types of arrangements, such as Associated Health Plans (AHP's.)

Please consider that our state laws and regulations are intended to make free markets work in New Hampshire, not to replace them or limit them. By passing SB110, the New Hampshire Business Council believes we will have set in motion the opportunity to restore a proper balance to the health insurance market. A balance where consumers are protected, greater market competition becomes a reality, lower premiums a viable possibility, and where insurance product innovation will be encouraged.

Thank you.

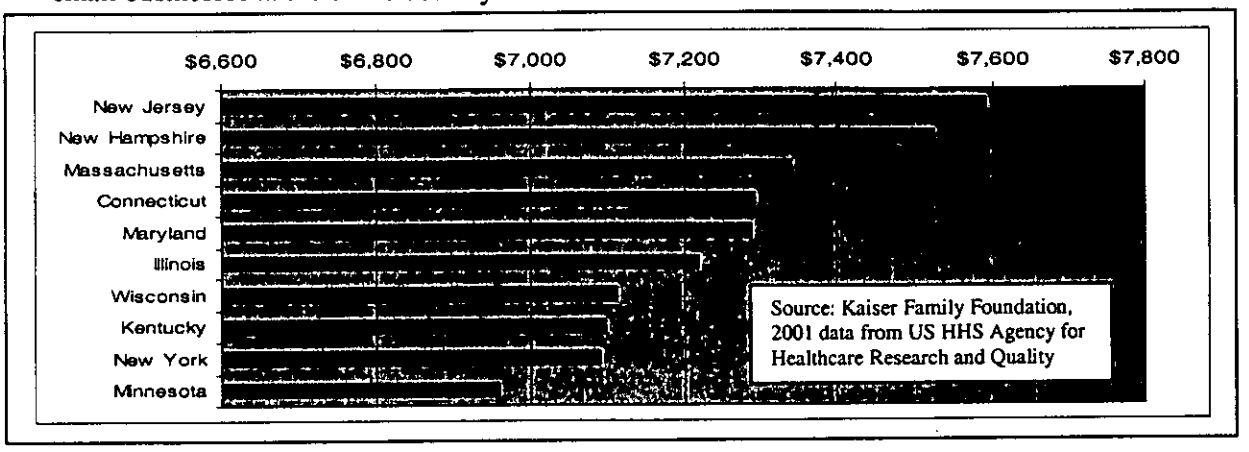
PS: As this proposed legislation progresses through the the Committee, there will be attempts to attach amendments. That is all fine and good but I urge you to not stray too far from the current text and get bogged down on what is good or bad about the amendments and their implications on the Bill Amendments can always be made in the future once SB110 becomes law. Right now SB110 paves the way for additional carriers to return to the State and start offering products to the market-place and create competition which in turn should lower costs.

Why New Hampshire Needs SB 110

"Restoring Insurance Choice for Small Businesses"

What is the problem?

New Hampshire currently has the second highest average family coverage health insurance rates for small businesses in the entire country.



Who is supporting SB 110?

Governor Craig Benson

■

NH Business Council

■

National Federation of Independent Businesses

■

NH Association of Insurance and Financial Advisors

■

NH Grocers Association

■

NH Lodging and Restaurant Association

■

NH Motor Transport Association

■

Retail Merchants Association of NH

■

NH Homeowner-Main Street Alliance

■

Milton Business and Industry Association

■

Independent Insurance Agents and Brokers of NH

■

Retail Lumber Association of NH

A big reason for these high rates is the lack of competition in the health insurance industry. Since legislative reforms were enacted in the mid 1990s more than two dozen insurance companies have left the state leaving New Hampshire consumers with just a few insurers to choose from.

How will SB 110 help?

Increase competition and bring back insurance carriers: SB 110 will bring New Hampshire in line with a majority of other states and create an environment that insurance companies will want to compete in. More insurance companies will mean more choices and lower prices for New Hampshire small businesses.

Protect New Hampshire's commitment to guaranteed access to health insurance for small businesses: SB 110 preserves NH's commitment to guarantee issue and renewability.

Ensure that high-risk groups are protected from price gouging: Under current law, insurers are not allowed to vary premiums based on risk factors. SB 110 would implement the National Association of Insurance Commissioners' model of small group insurance laws (similar to 37 other states), which limit increases due to changes in a group's health status or claims experience. Increased claims won't lead to run away insurance costs.

Lower insurance costs: Similar reforms were enacted in the individual insurance market in July of 2002. Since then Anthem Blue Cross/Blue Shield has lowered their prices by as much as 40%. In addition, new insurance providers have begun to offer lower costs alternatives and a variety of insurance products.

Preserves sole proprietors ability to purchase group insurance: Sole proprietors are important to the New Hampshire economy, and SB 110 preserves their ability to purchase group insurance.

Competition can only mean lower insurance costs

For more information please contact Erik Taylor at 800-528-1181

HIAA®

Health Insurance Association of America

TESTIMONY IN SUPPORT OF REFORMS TO THE NEW HAMPSHIRE SMALL GROUP HEALTH INSURANCE MARKET SENATE BILL 110

BY ANGELA FRANKLIN
LEGISLATIVE DIRECTOR & COUNSEL

APRIL 23, 2003

Good afternoon to the Chair and members of the Commerce Committee. HIAA is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. It is the nation's premier provider of self-study courses on health insurance and managed care.

I am Angela Franklin, Legislative Director and Counsel for the Health Insurance Association of America and I am here to express our strong support for **Senate Bill 110**. We believe the enactment of the bill will help improve the availability of health insurance coverage for New Hampshire consumers.

As a result of well-intentioned legislation enacted in the early to mid 1990s, the State of New Hampshire has in place laws that make it difficult for private insurers to compete in the individual and small group market and to some extent, in the large group market. This has caused a number of private insurers to withdraw from the market. Many individual consumers and small businesses have effectively lost the ability to choose from competing private insurers, and at the same time are having to shoulder growing heath care costs.

S.B. 110 builds on recent efforts by forward-thinking lawmakers to reinvigorate New Hampshire's small group market and offers the legislature an opportunity to help recreate a business climate that is attractive to insurers and beneficial to consumers. As indicated by our members today, S.B. 110 will improve the health insurance market in New Hampshire by encouraging competition to return and providing more choices for providers and consumers. We applaud the sponsors and the efforts of the coalition of New Hampshire insurance agents who play an important role in New Hampshire's economy and who are strong supporters of these bills.

S.B. 110 will allow some rate flexibility in the small group market in ways that reflect the NAIC Model and also reflect what most states have done. Currently, insurers in New Hampshire are required to use an average or index rate for all small groups and to

"guarantee issue" to any small group that comes to them. The result is similar to the individual market where adverse selection causes the sicker and more costly groups to buy insurance and the healthier groups to have to pay more than they should or to drop coverage altogether. This drives up the average rate increasing both the cost of insurance and the number of uninsured. In fact, a January 2000 study by the congressional budget office states that the prevailing rate compression laws in the states are responsible for 1.7 million fewer people having insurance and that is based upon the assumption that rates can vary from the average by ±20%. This process can accelerate over time leading to what is called a "death spiral" of the private market, particularly in the small group and individual markets. New Hampshire has been moving in this direction for some time and is one of only 12 states to disallow any commonly accepted rating flexibility in the small group market.

We strongly support **SB 110** and urge the legislature to enact this measure. We must caution however, that after these reforms are enacted, it takes time for more insurers to be convinced that the changes will be helpful and that a company should return to what has been a difficult market in the past. The regulatory environment is a big factor, and once a decision to return is made, marketing systems must be recreated, people must be hired or reassigned, budget and other resources must be allocated, regulatory filings must be made and approved, etc. The state of Kentucky provides a good example. In the early 1990's, Kentucky enacted legislation that had many similarities to New Hampshire's current system. This led to over 40 insurers leaving the state's insurance market at that time. Recognizing its mistake, in 1998, 99 and 2000, Kentucky passed legislation intended to bring private insurers back to their state by repealing much of the 1992 changes and enacting some new provisions, including a risk pool. Several insurers have returned, and others have recently announced their intent to return to the Kentucky market, however, it will likely be some time before the market returns to pre-1992 conditions where multiple insurers were actively competing for business.

For questions about this testimony, please contact Angela Franklin, legislative director and counsel at the HIAA in Washington, D.C., 202-824-1667.

ATTACHMENT

Michael J. DeCarlo, Esq., HIAA Director and Counsel for Policy Development, "Why Are Premiums For Small Employer Health Insurance Going Up And What Can Policymakers Do About It?" August 2002

HIAA®

Health Insurance Association of America

Why Are Premiums For Small Employer Health Insurance Going Up And What Can Policymakers Do About It?

I. EXECUTIVE SUMMARY

Recent years have seen a return to double-digit annual increases in the cost of health insurance, causing great concern for employers, consumers, policymakers, and insurers alike. As premium rates rise, small employers are finding it especially difficult to afford coverage.

State and federal policymakers looking for ways to address this problem should recognize that increases in health insurance premiums are primarily caused by rising health care costs. Health care costs are increasing for a variety of reasons, including higher hospital and other provider reimbursements, overly restrictive regulation of small employer coverage, increasing government mandates, an aging American population in need of more health care, greater consumer demand for expensive technologies and drug therapies, a lack of incentives for consumers to control spending, higher litigation and risk management costs, cost shifting from public programs, and general inflation.

Section III below offers a number of recommendations to make health coverage more affordable for small employers. Any public initiative in this area must recognize the unique nature of the market for small employer health insurance and the role that insurers play in financing health care coverage. Most important, policymakers should avoid false "fixes" such as stringent regulatory controls on health insurance premium rates. Rate controls do nothing to address the problem of rising health care costs. Instead, they drive up the price of insurance, reduce consumer choice, and lessen competition.

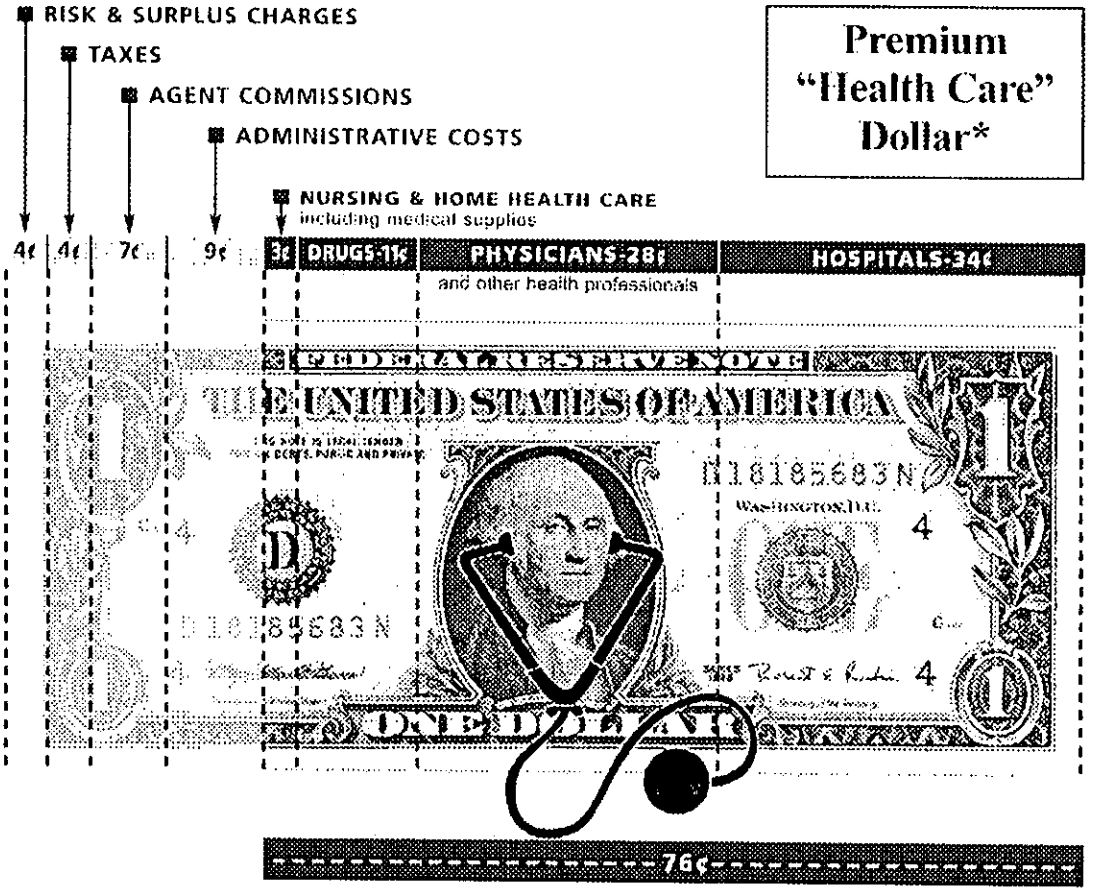
II. DISCUSSION

We are all concerned about rising health insurance premiums and the impact rising costs have on employer-sponsored health insurance, especially insurance sponsored by small employers. To develop solutions to this problem (and avoid false "fixes"), we must understand the factors driving premium increases, the role of insurers in the financing of health care, and the unique characteristics of small employer health coverage.

A. Why Are Premiums Going Up?

As the figure below illustrates, roughly 76 cents of each dollar spent on premiums for medical insurance goes to pay for health care expenses incurred by enrollees. The remaining 24 cents of each premium dollar is spent on administrative functions and other costs not directly related to paying for health care[1], which include processing claims, consumer services, agent commissions, taxes, and profit. (The profit margin for small employer health insurance is narrow—between

0.7 and 5.5 cents on each dollar). It is easy to see that changes in health care costs have a significant effect on the cost of health insurance. Indeed, ***rising health care costs is the primary reason premiums are increasing.***



*Source: HIAA survey, June, 2002

B. Why Are Health Care Costs Rising?

Higher premiums are primarily the result of higher health care costs. But what is causing health care spending to rise? A number of factors:

- **Higher hospital and other provider costs.** Hospital mergers over the last few years have resulted in less competition and greater negotiating power with health insurers. Hospitals also are "cost-shifting"—that is, charging private insurers more to offset lower payments by Medicare and Medicaid. In addition, the cost of new medical technology and increasing wage costs fueled by a shortage of nurses are requiring hospitals to charge more for their services.[2]

- **An aging population and increased consumer demand**. As Baby Boomers age, our population as a whole is getting older.[3] Older Americans use medical goods and services more frequently and need more costly care.[4] In addition, all consumers—both young and old—are using more, and more costly, health care, including sophisticated medical technologies and screening tests like MRIs. Consumers also increasingly are demanding health insurance plans that are more expensive because they incorporate less managed care and offer a greater choice of health care providers.

- **Greater use of expensive drugs, medical devices, and other medical technologies**. Rapidly rising spending on prescription drugs is one of the major drivers of health care costs. It is estimated that retail spending on outpatient prescription drugs in the U.S. rose 17.1 percent from 2000 to 2001.[5] This increase comes on the heels of similarly large increases in prescription drug spending over the last five years.[6] Spending on prescription drugs is expected to continue to rise. Spending on medical devices and other medical technologies also is going up.

- **Lack of incentives for consumers to control spending and lack of information to evaluate quality**. Consumers are highly insulated from the cost of health care and have little information about the quality of the care they receive. Unless this situation changes, demand for health care goods and services will continue to rise unabated and it will be difficult to bring improvement to the quality of care.

- **Overly restrictive regulation**. State and federal regulations restricting the ability of insurers to adjust premium rates to reflect higher risk have made small employer insurance more expensive and therefore less attractive to healthier individuals and groups. As healthier small groups and individuals drop coverage, premiums for those who are left must go up. The U.S. General Accounting Office reports that small employer premiums in states with the most stringent restrictions are 6-7 percent higher than in other states.[7]

- **Increasing government mandates**. Employers and other purchasers of health insurance now face over 1,500 mandated benefits at the state and federal levels, and many more mandates are added each year. The number of mandates states have placed on health insurance plans increased at least 25-fold between 1970 and 1996.[8] In addition to benefit mandates, states also have enacted numerous "provider" mandates. These mandates, which require coverage for specific types of providers—for example, chiropractors—also add considerably to the cost of coverage and restrict the ability of consumers to choose for themselves the type of coverage they believe is most appropriate for their needs. The cost of a single mandate may be small, but collectively, mandates add tremendously to the cost of coverage. Indeed, it is estimated that one-fifth to one-quarter of the uninsured cannot afford coverage as a result of state mandates.[9]

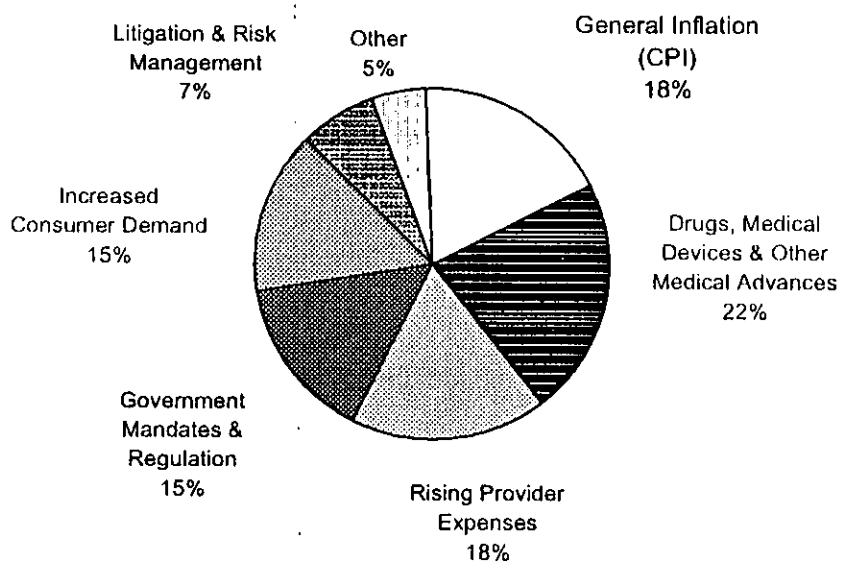
- **Higher costs for litigation and risk management**. Litigation involving health care has grown dramatically over the last 20 years, resulting in greatly increased costs. Soaring malpractice insurance rates mean that health care providers must charge higher fees for

their services, and the increased threat of lawsuits forces doctors to perform unnecessary tests and procedures.[10] More recently, plaintiffs' lawyers have targeted health insurers and employers as they seek large-dollar awards, in some cases launching massive class action lawsuits.

- **General inflation**. Because of general inflation, the price of most goods and services goes up over time. Health care is no exception.

A recent study by PricewaterhouseCoopers [11] estimated the degree to which these and other factors contributed to the increase in health insurance premiums over the period 2001-2002. Chart 1 below shows the percentage of the total increase in premiums attributable to each factor.

Chart 1
The Factors Driving Rising Costs in Healthcare (2001-2002)



Source: PricewaterhouseCoopers, April 2002.

Not all of the reasons that Americans are spending more on health care are necessarily bad. Advances in medical technologies, including advances in drug therapy, allow individuals to live longer, healthier lives. Higher wages for physicians and other health care workers help attract the best and the brightest to the field of medicine and ensure high quality care. That said, it is important to understand the sources of higher health care spending so that we can assess ways to prevent costs from running out of control.

C. What Role Do Health Insurers Play?

Health insurers perform a variety of functions in the financing of health care. These include:

- **Providing the means for employers to finance employee health benefits without being exposed to unreasonable financial risk.** Many large employers self-insure their employee health benefits. Health insurers make it possible for small employers to offer their employees similar benefits.

- **Reimbursing health care providers for medical services and monitoring claims to minimize fraud and abuse.** An important part of the health insurer's role as payer is to help keep the cost of premiums in check by working to detect and control fraudulent and abusive practices, such as charging for services not received, "upcoding" claims for services, providing unnecessary or inappropriate services, and charging excessive fees. In 1998, health insurers saved $11 for every $1 spent on anti-fraud programs.[12]

- **Negotiating the best possible rates with health care providers while providing the broadest possible access to physicians and facilities.** Insurers keep costs down by offering health care providers a greater volume of business in return for lower rates. In this way, insurers pool the negotiating power of their policyholders. Preferred provider organizations (PPOs) and other "network" plans allow insurers to obtain the best possible rates by guaranteeing greater volume to providers. Thus, these plans are less costly than those offering an unlimited choice of providers. Many network plans offer individuals the option of obtaining services from providers outside the network, but at a higher cost. Much like a network plan, prescription drug formularies enable insurers to negotiate lower prices on prescription drugs in return for offering drug manufacturers a higher volume of sales. Formularies also give consumers an incentive to use lower-cost generic drugs, which helps keep down the cost of insurance for everyone.

- **Educating enrollees.** Insurers increasingly provide programs to educate enrollees about maintaining their health and to encourage them to seek the best possible preventive care and treatment. These programs can help individuals improve their quality of life and keep health care costs in check.

- **Constantly assessing market needs and striving to deliver a range of innovative products to meet unique employer needs and budgets.** Competition drives health insurers to assess the needs of their customers constantly and to look for new ways to deliver the highest quality coverage at the lowest possible cost.

D. Why Is The Small Employer Health Insurance Market Unique?

To ensure a competitive, functional market for small employer medical insurance, it's necessary to recognize certain unique dynamics at work. The market for small employer coverage is subject to two important forces: (1) State and federal regulation that seeks to maximize access to coverage; and (2) "adverse selection"—that is, the tendency of healthier small employer groups

and individuals to place a lower value on insurance and therefore be less willing to pay for it when the cost of insurance goes up. These two forces are in conflict and can lead to problems if regulation fails to leave insurers enough flexibility to deal with adverse selection, as has occurred in some states.

The major aspects of state and federal regulation designed to increase access to small employer coverage include:

- **Guaranteed issue and guaranteed renewal.** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state law, insurers offering medical expense coverage to small employers (generally defined as employers with 2-50 employees) must offer the coverage on a "guaranteed issue" basis. This means that no small employer can be turned down for coverage. In addition, small employer coverage must be offered on a "guaranteed renewal" basis—that is, the coverage can be cancelled only for certain limited reasons such as failure to pay the premium. These requirements mean that small employers are free to purchase, drop, and repurchased health coverage at will.

- **Limitations on the degree to which insurers may adjust small employer premium rates based on risk.** Most states restrict the degree to which an insurer, taking into account the health status of enrollees, may vary the premium rate for a small employer from the average rate charged to all small employers in the state. This type of restriction is known as a "rate band" because the premium rate for any small employer may be adjusted based on health status only within a limited "band" around the average rate for all small employers. A few states permit no variation in rates based on health status. Most states permit additional adjustments based on the demographic characteristics of enrollees, such as age and gender. Federal and state law provides that only the rate for the small employer group as a whole may be adjusted based on health status. Individual members of a group may not be singled out for a higher or lower rate based on their health.

- **Limitations on exclusions for preexisting conditions, required portability of coverage, and guaranteed acceptance of all eligible employees.** Federal and state law limit the maximum exclusion period for a preexisting condition for employer-sponsored coverage. In most states, the maximum exclusion period is 12 months. No exclusion period may be applied for pregnancy. In addition, insurers are required to credit prior continuous "creditable coverage" towards any applicable group preexisting condition exclusion period. Federal and state law also require employer health plans to offer coverage to all eligible employees, regardless of health status. Employees who decline coverage when it is first offered and do not have another source of coverage may become ineligible for benefits or be subject to a longer preexisting condition exclusion period.

- **A few states apply these regulations to "business groups of one"—that is, self-employed individuals with no employees.** Congress specifically allowed states to include one-person businesses in the group market.

State and federal laws governing small employer insurance improve access to coverage but leave the market more open to the damaging effects of adverse selection. Adverse selection presents a problem for small employer health insurance because:

- **Healthy individuals and groups value insurance less and tend to forego coverage when the cost is high.** Health insurers can maintain reasonable premium rates only if they can price coverage at a level attractive to healthier individuals and small employer groups. If healthier persons drop coverage, premium rates must go up for those who are left. Experience shows that there is a limit to the extent to which healthy small employers are willing to subsidize less healthy groups.

- **In many cases, the decision to purchase insurance is based on the health status of one individual (usually the owner of the business) or just a few individuals.** This is especially the case for employers with five or fewer employees.

- **Even where a small employer's decision to obtain coverage is based on factors other than health status, the decision of individual employees may turn on this consideration.** As a group, small employers ask their employees to contribute more to the cost of health insurance than large employers.[13] In addition, workers in small firms have lower wages on average than employees of larger establishments.[14] Thus, the dollars the employees of small firms must spend to obtain health insurance represent a greater proportion of their income. For these reasons, workers in small firms have a greater incentive to forgo coverage if they are healthy.

- **Adverse selection also can work harm between different types of coverage.** Individuals have a strong incentive to purchase limited coverage when healthy and then "trade up" to more expensive coverage if their health condition worsens. This, too, drives up the cost of coverage and may reduce the choice of plans available to small employers as insurers seek to reduce their exposure to adverse selection.

To combat adverse selection, health insurers must be able to discount the price of coverage for healthier small groups so that the cost of insurance is attractive to the group and the individuals in it. Laws that overly restrict the ability of insurers to adjust rates based on health status prevent this from occurring. At the same time, rating restrictions coupled with guaranteed issue reduce the incentive for groups to obtain coverage and maintain it before a health condition presents itself. As a result, healthier groups and individuals tend to forego coverage, causing premium rates to rise for those who are left in the market and driving up the number of persons without insurance. A number of studies have documented these problems:

- The U.S. General Accounting Office found that small employer premium rates in states that permitted no adjustment in rates for health status were 6-7 percent higher than in other states.[15]

- Two recent studies by an economist now at Cornell University found that—
    - In states that adopted rate bands, the rate of coverage for workers in small firms declined by almost two percent on average as a result.
    - This decline in coverage occurred predominately among healthier "low risk" workers. There was little evidence to show that less healthy, "high risk" workers benefited from the regulations. Rates of coverage among these workers changed very little, if at all, due to the new controls.
    - In states that adopted rate bands, small employer health insurance premiums increased by about four percent on average as a result. Most of this increase was passed on to workers in the form of higher employee contribution levels.[16]

- A January 2000 report from the Congressional Budget Office evaluating major studies of state small group regulation concluded that rate bands in the states are responsible for 1.7 million fewer people having health insurance.[17]

- A 1998 study by researchers at the Urban Institute found that premium rate restrictions in the market for small employer health insurance were "clearly associated with lower rates of private and overall health insurance coverage."[18]

These findings are entirely consistent with the experience of HIAA's members with the regulation of small employer coverage. Moreover, these conditions make it difficult for insurers to do business in a state. Many insurers have been unable to maintain a presence in states with the most stringent small group restrictions, leaving consumers with fewer options and a less competitive market. Once insurers leave a state market, it is very difficult to attract them back due to the investment required for reentry and risk concerns. In addition, federal and state law provides that an insurer that leaves the small group market in a state may not return for five years.

III. WHAT SHOULD POLICYMAKERS DO?

Experts expect health care costs to continue to rise. Staying the current course will result in an increasing number of employers no longer able to continue offering or subsidizing employee health insurance plans. In view of the significant number of Americans who receive their health care coverage through their employer, policymakers should do more to promote meaningful alternatives and solutions. There is no single way to address this problem, but policymakers should consider the following actions:

- **Avoid harmful market restrictions.** Overly restrictive regulation of small employer insurance drives up the cost of coverage, leaves fewer individuals with insurance, and reduces choice and competition. Policymakers should recognize the trade-offs inherent in such reforms and strive to leave insurers with sufficient flexibility to cope with adverse selection. Most states have struck a balance here, but a few have gone much too far, with resulting damage to their markets.

- **Limit small group market regulation to employer groups of 2-50.** So-called "groups of one" present too great a risk of adverse selection for the small employer health insurance market. Because of adverse selection, the cost of insuring individuals on a guaranteed issue basis is extremely high, and this cost is borne solely by small employers when guaranteed issue and other small group reforms are extended to one-person "groups." Individuals should purchase coverage through the individual market, with the cost of guaranteed access spread broadly through a high-risk pool for those who cannot obtain private coverage because of a preexisting condition. Small group market restrictions also should not be expanded to employers with more than 50 employees. Access to coverage is not a problem for employers of this size. Subjecting them to small group restrictions will only cause healthier groups to self-insure, making premium rates rise for small employers left in the regulated market.

- **Eliminate mandates.** States and the federal government should place a moratorium on new benefit and provider mandates. Existing mandates should be repealed, or at least changed to mandatory offer, rather than mandatory coverage.

- **Expand tax relief or offer other premium assistance for insurance sponsors by small employers.** Among small firms that do not offer health coverage, 72 percent say that cost is the primary barrier.[19] Expanded tax relief and other forms of premium assistance for small employers who sponsor insurance would address this fundamental problem head-on by reducing the cost of coverage to them. Moreover, since over 80 percent of uninsured Americans are either workers or live in a household with at least one full-time worker,[20] targeted assistance to employers would do much to reduce the number of uninsured. Premium assistance to small employers also has an number of other attractive qualities:
    - Combining public subsidies with employer contributions allows public dollars to be stretched further to potentially cover more people.
    - Because the assistance goes toward employer-sponsored coverage—the primary source of coverage for non-elderly adults—it may help avoid the stigma often associated with public programs.
    - Premium assistance often allows children and parents to share the same source of coverage, which studies indicate increases the likelihood that families will seek and obtain needed medical care.[21]

  At least 16 states and localities are experimenting with such programs.[22]

- **Avoid creating unreasonable administrative burdens for insurers.** These include, for example, inconsistent reporting and disclosure requirements, onerous product and rate filing requirements, lengthy delays for new product approval, and unreasonable "prompt pay" laws.

- **Permit insurers to build cost-effective provider networks with meaningful incentives for the use of preferred providers.** Avoid establishing onerous "any willing provider" requirements that eliminate the ability of insurers to negotiate

volume discounts with health care providers. Such requirements bring higher fees for providers, but only by reducing competition and ultimately harming consumers.

- **Encourage benefit arrangements that involve consumers in the cost and delivery of their health care.** Too many people believe that a visit to the doctor's office or filling a prescription for an antibiotic costs them just $10. The true cost of the health care they receive is hidden behind their insurance coverage. Many insurers are beginning to introduce products to correct this problem by giving consumers greater control over their health care spending and providing incentives for consumers to demand higher quality care at a lower cost. Typically, these products combine insurance for catastrophic and chronic care with a health care spending account for routine medical expenses. But federal and state tax laws create barriers to such products—most notably, by limiting the ability of consumers to "roll over" unspent dollars in a tax-free medical spending account from year to year. Policymakers should remove these barriers in federal and state tax law. In addition, consumers have too little information about the cost and quality of the health care they receive. Policymakers should require health care providers to disclose their prices in an understandable manner and should assist the private sector in developing meaningful health care quality measures.

- **Enact strong medical liability reforms and avoid creating new causes of action against employers and insurers.** In a 1995 study, researchers at Stanford University found that health care liability reform lowered health care costs by 5-9 percent among Medicare patients treated for serious heart disease with no appreciable impact on health outcomes in states that limited non-economic damage and punitive damage awards.[23]

- **Address the problem of cost shifting by ensuring that providers receive adequate reimbursements from Medicare and Medicaid.** It is tempting for public officials to shave dollars from social insurance programs by reducing reimbursements. But this is a false economy, as the cost of under-reimbursed care is shifted directly to private payers and, ultimately, consumers.

- **Avoid structuring small employer health insurance purchasing cooperatives in a way that would segment the market into the healthy and the sick.** Many states have established programs to help small employers band together to purchase health insurance, and many more are considering establishing such programs. Congress also is considering legislation to encourage cooperative purchasing arrangements. It is critical that these initiatives apply the same set of legislative and regulatory rules to coverage sold through the cooperative purchasing arrangement as apply to coverage sold outside the arrangement. For example, exempting cooperative purchasing arrangements from state benefit mandates without creating a similar exemption for the rest of the small employer insurance market will encourage healthier small employer groups to purchase coverage through the cooperative, increasingly leaving less healthy groups in the outside market. The result will be a segmentation of the

insurance market into the healthy and the sick, with less healthy small employer groups paying much more for coverage.

ENDNOTES

[1] Based on a June 2002 survey of 9 HIAA member companies with total 2001 small group premiums of $8.1 billion. Administrative costs in the *large group* market have been shown to be roughly 10% of the premium dollar. Some administrative functions, such as billing and marketing, are unavoidably more costly on a per employee basis for small group as compared with large group coverage. Some services that insurers provide to small employers do not show up as insurer administrative costs in the large group market because employers carry out the functions themselves, such as handling employee questions about coverage or claims. Further, state insurance premium taxes and insurance risk charges, both of which are built into small group insurance premiums, are not incurred by self insured large employers. See "Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage," GAO-02-8, U.S. General Accounting Office (October 2001), pp. 13-15.

[2] "Back to the Future? New Cost and Access Challenges Emerge," Issue Brief No. 35, Center for Studying Health Systems Change (February 2001); "Future Trends in Health Care Inflation and Utilization," *HealthINFLATION News*, available at www.healthinflation.com (accessed May 5, 2002); "U.S. Employers' 2001 Health Benefit Costs Took Highest Jump in 10 Years," Issue 119, *The Mercer Report* (March 15, 2002).

[3] In 1980 the median age of the U.S. population was 30 years. In 2000, the estimated median age was 35.8. By 2025, the median age is expected to reach 38.5. Bureau of the Census, *Statistical Abstract of the United States* (2000).

[4] On average, health care spending by an American male age 45-54 is double that of a male age 35-44. Spending increases another 50 percent for a male age 55-64. PricewaterhouseCoopers, "The Factors Fueling Rising Health Care Costs" (April 2002).

[5] "Prescription Drug Expenditures in 2001: Another Year of Escalating Costs," National Institute for Health Care Management Research and Educational Foundation (May 6, 2001).

[6] *Id.*

[7] "Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage," GAO-02-8, U.S. General Accounting Office (October 2001).

[8] G. Jensen and M. Morrisey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," prepared for the Health Insurance Association of America (January 1999).

[9] *Id.*

[10] "Doctors across the board and around the country are facing double-digit hikes in malpractice premiums." *USA Today* (December 4, 2001). "In 2001, physicians in eight states saw two or more medical liability insurers raise rates by 30% or more: Arkansas, Connecticut, Illinois, Nevada, North Carolina, Ohio, Pennsylvania & Texas." A dozen states saw rate increases of 25% or more. *American Medical News* (January 7, 2002).

[11] "The Factors Fueling Rising Health Care Costs," PricewaterhouseCoopers, prepared for the American Association of Health Plans (April 2002).

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April 23, 2003

House Commerce Committee
SB 110: Small Group Health Insurance Market Reform Act

Submitted By: Yvonne Nanasi, Government Relations Director (603/695-7354)
Presented By: Ron Becker, Director Actuarial Services and Larry Hart, Director Underwriting

Anthem Blue Cross and Blue Shield (Anthem BCBS) is concerned that SB 110 will cause significant disruption in the small group market for some employers. It encourages competition among health insurers based on risk selection not on the basis of quality, health outcomes and disease management. Nor does SB 110 address the central issue - the cost of health care.

Overview of Impact of SB 110 – NH Small Group Market Reforms

Anthem BCBS has closely analyzed the impact of SB 110 on our current small employer book of business. The segment of small employers whose premiums will increase significantly over the next three years, due to SB 110, will be those whose employees need insurance coverage the most.

Changing the definition from 1-100 employees to 1-50 employees

Employers with 51 or more employees will be defined as a "Large Group"

Employers in this category (those with 51 to 100 employees previously included as a small group) will have their premiums calculated differently than when they were defined as a "small group". As a large group, the employer's premium could increase annually by an unlimited amount for various underwriting factors. This increase is absent the medical trend factor that is currently about14%-17% that would be added to any other increase in premium factor.

The limits on premium increases that are required in the newly defined small group market (2-50 employees) for various underwriting factors (age, health status, industry type, claims experience and geographic location) are not required when the insurer is pricing premium for large employer groups. Essentially, the 25% increase cap would not apply to groups over 51 employees.

Furthermore, for "large groups", the underwriter relies more on prior claims history to calculate premium. This means that the group's claims experience is an important factor in calculating premium. If the group has a higher than average claims cost over one or a couple of years, it is considered when setting the premium. Employers with 51-100 employees that had previously been in the small group market will find that a few high claims incidents (a premature baby, extensive cardiac surgery, or kidney failure) in their workforce could dramatically increase premium.

IMPACT OF NEW RATING FACTORS THAT CHANGE HOW PREMIUM IS CALCULATED

Employers of 1 to 50 employees will have premium calculated very differently

Since 1994, the only rating factor that would increase rates for a small employer more than the average employer in the state has been the aging of employees. SB 110 adds several new rating factors that can vary the premium dramatically and changes the age band ratio-rating factor. These rating factors are not allowed under the current small group health insurance law.

USA

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Testimony presented by Mary Lucas Atwood. Ms. Atwood has over 20 years of experience in the insurance and health care industry. She is no longer employed by an insurer and owns a small business. Ms. Atwood takes this position because she believes that Senate Bill 110 will have an adverse effect overall for the small employer groups of NH.

Fallacy Number One – Changing the small group legislation will save the small employers of the state money.
The proposed legislation assumes that changing the rating methodology for small groups will reduce the overall cost of healthcare in the state. **The total amount of costs will not be reduced, they will just be redistributed – probably to those who can least afford it.** The cost for healthcare in the state is the result of the health of the population and the lack of competition among the providers. You can change how groups are rated and how the costs are distributed in the form of premiums, but the legislation will not change the underlying costs. They will remain the same.

The governor is quite aware of this fact. He made the decision at Cabletron a few years ago to get rid of all the insurers and self-fund. He then went to Frisbee Hospital and negotiated favorable fees with the hospital for serving his Cabletron employees.

Fallacy Number two – Bringing more insurers into the state will lower premiums.
The insurers do not control the underlying costs of healthcare. The source of the costs is with the providers and utilization. The governor knows this or he would not have gotten rid of the insurers and negotiated directly with the providers. In addition, any insurer coming into the state will need to negotiate with the providers and get favorable rate schedules in order to compete with the insurers who are already here. They will have a very difficult time getting decent contracts with the providers because they don't have a base of members to leverage their negotiations. Therefore, they will structure the benefit plans so that only the young and healthy individuals will join their plans. They will place less emphasis on efficiency and risk management and an increased emphasis on competing on the basis of risk selection. **The insurers will be fighting for the best risk – how will we as a state deal with the risks the insurers don't want?**

Fallacy Number three - Medical underwriting will save the employers money.
Illness is highly unpredictable and may strike even the young. Including medical underwriting as a part of this legislation is a step back in time for small employers. Moving away from community rating adds costs for the insurers in the form of underwriting overhead and these costs will be passed on to the employers. The application of rating factors such as age, group size, industry classification, geographic location, and health status give the insurers the advantage – not the employers. The market cap of 25% through 1/1/05 gives little comfort when you also have to add medical trend (14% - 18%). And what is going to happen in two years?

Fallacy Number four – Defining small group as 1 to 100 and community rating these groups takes away from the New Hampshire advantage.
The proposed legislation is going to add a whole new level of uncertainty for small employers, particularly if medical underwriting is introduced as a part of the equation. And we all know business people hate uncertainty. Employers now will have to worry about the impact on their health care costs if they get sick or if they hire someone with a sick dependent. Will this proposed legislation introduce discrimination into the work place? Small companies typically know if one of their employees or a dependent is sick.

The most basic of all insurance principles is the 'law of large numbers.' In other words, big risk pools are good because you can spread the risk over a large number of people. Defining small groups as 1 to 100 creates a large risk pool. And community rating for these groups removes a level of uncertainty for the small employers of this state. **Taking uncertainty out of the equation for the small employers of this state creates the New Hampshire advantage.**

Age Band Ratio change from 3:1 to 4:1
Currently, premium adjustments are made based on the age of the employees in the group. Increasing the ratio shifts the cost to the oldest age groups and lowers premium for young employees. Anthem BCBS estimates that for employees under the age of 55 years, the rate would be about 3.25% less and for those from 55-59 years would be about 10.5% less. But for those over age 60 years, premium would increase by about 13.5% and for those over 65 yrs would increase 29%. This increase is absent the medical trend cost factor that is currently about14%-17%.

Adding Health Status Rating Factors to Small Group Premium Calculation
Currently, an insurer cannot require a small group to submit health status information from employees to calculate premium. Under SB 110, prior to quoting a premium cost to the group, employees may be required to submit to the insurer a health status questionnaire. This questionnaire will ask about health conditions that employees and their family members have sought medical services for such as asthma, diabetes, high blood pressure, and other conditions. Based on the response to this health status questionnaire, the employer's premium could increase over the average rate by not more than 25%.

If the employer has more than the expected incidence of persons with health risk indicators in the group, the rate will be increased over the average rate. At this time, NH employers probably have no knowledge about the incidence of persons in their workforce with health risks as the state has been community rated since 1994 and these conditions weren't taken into account. Furthermore, the wellness and healthy lifestyle practices of employees who have health risk factors are not necessarily taken into account when rating for health status.
This increase is absent the medical trend factor that is currently about14%-17%.

Adding SIC Code (industry type) Rating to Small Group Premium Calculation
SB 110 would allow insurers to rate up small employers' premium by up to 20% for the employer's industry type. Some industry types are considered more risky than others for higher claims potential. Anthem BCBS's analysis indicates that numerous SIC codes for NH small employers in hotel, lodging and food service, health care providers, auto and personal services, transportation, social services, professional associations, lumber operations and government entities would be open to a 10%-20% premium increase based on accepted industry risk factors. This increase is absent the medical trend factor that is currently about14%-17%.

Adding Geographic Rating Factors to Small Group Premium Calculation
Medical services cost more in the Seacoast and North Country than in other regions of the state. Small employers located in the more costly regions could experience an increase of up to 15% based on this rating factor. This increase is absent the medical trend factor that is currently about14%-17% per year.

HOW COULD SB 110 IMPACT SMALL EMPLOYERS UNDER 51 EMPLOYEES?
Which employers (under 51 employees) could experience higher premiums as a result of SB 110?

- Businesses located in the Seacoast and North Country Regions were medical services are more expensive
- Businesses with employees over 60 years old
- Businesses with employees or their dependents with health conditions (diabetes, asthma, high blood pressure, cancer, HIV, heart disease, etc.).
- Business types such as health care services, auto repair, personal and home services, transportation, lodging, food service, social services, construction, etc.
- Business that qualify under all of the above rating and age band changes COULD HAVE PREMIUMS INCREASE OVER THE NEXT 3 YEARS by 55%-72% more than other businesses.

Comparisons with Other States

The health insurance premiums in New Hampshire when compared to other states needs serious analysis before one can surmise that competition would be a driving force to lower rates. One significant factor that drives the cost of health care in New Hampshire is the cost shift from Medicaid and Medicare. This cost shift could increase given the proposals in the proposed State Budget.

Other states that have rating mechanisms similar to SB 110 also have other mechanisms that address market disruption, but SB110 does not employ any of them. One is to mandate that a limited number of standard plans including high option plans be offered. Perhaps the fairest and best performing mechanism is some form of risk-adjuster or risk pool. Connecticut has a reinsurance pool that carriers can cede risks to at the time of enrollment. When CT transitioned from community rating, a level playing field was achieved by allowing the existing carriers to make a one-time ceding of their existing risks. According to data on the CT DOI web site there are twenty-six carriers who have approved " blue ribbon" small group products available. That list includes John Alden Life, Fortis Benefits Insurance and United Healthcare. NH has adopted a high-risk pool for individual coverage and that market is booming and attracting new entrants. Something similar could work for small group and be much fairer to those small groups that will be adversely impacted.

Anthem BCBS believes that there are other alternatives to addressing the rising cost of health insurance that don't include "turning back the clock to pre-'94". Disease management programs and collaborations with providers on these programs are being implemented. Cost savings can be achieved from these programs without discrimination against those with health conditions.

SUMMARY

SB 110 is a radical shift from the current method of calculating health insurance premiums for small employer groups. We are likely to see most of the competition centered around benefits designed to attract young healthy people and cost shifting - not innovative clinical quality or disease management programs that seek to lower utilization (costs) for the 5% that use 50% of health care services.

NH does not have an extensive population base to support a large number of carriers. Nobody has modeled what might be an optimum number, but it may not be much larger than what we already have. For the same reason retailers such as IKEA, Tiffany, Lord & Taylor, Sake Fifth Avenue, or Nordstrom don't have stores in New Hampshire.

New Hampshire's status as having one of the lowest rates of uninsured in the nation (about 9% based on recent surveys) and our status as one of the healthiest states in the nation says a lot about how well the state's insurance market and health care system is working. What is working needs to be retained. SB 110 seeks to address the needs of the carriers who are interested in the NH market not the needs of the health care system. This radical shift needs much more study by health care economists and others who are unbiased and can articulate how best to maintain what is working without increasing rates for those who have health conditions or are in areas or industries that call for higher premiums in a difficult economic climate.

Because of the lead times involved third quarter, rates effective, July 1, 2003 are currently being quoted in the market. It would provide for a smoother transition if the effective date were postponed until January 1, 2004.

As the Blue Cross and Blue Shield plan licensee in the state, Anthem BCBS is committed to providing health insurance coverage to individuals and employer groups in New Hampshire. Anthem BCBS is available to assist Representatives in their deliberations on SB 110 and provide any assistance that is requested.

Health First Health Plans, Inc.

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HEALTH STATUS QUESTIONNAIRE

(For Employer Groups of 1 To 24 Employees Enrolled)

Please complete all questions for Yourself (and your Dependents, if dependent coverage is being requested)

NAME	RELATIONSHIP	SS#	Sex	Date of Birth	Height	Weight
Employee Name						
Dependent Name						
Dependent Name						
Dependent Name						
Dependent Name						
Dependent Name						

A. Have YOU or any of your DEPENDENTS consulted with, been treated or examined by any physician or other practitioner for any of the following conditions?

	MEDICAL CONDITION	Yes	No		MEDICAL CONDITION	Yes	No		MEDICAL CONDITION	Yes	No
1.	Arthritis	☐	☐	19.	Epilepsy	☐	☐	37.	Attempted Suicide	☐	☐
2.	Rheumatoid Arthritis	☐	☐	20.	Parkinson's	☐	☐	38.	Anorexia/Bulimia	☐	☐
3.	Osteo Arthritis	☐	☐	21.	Alzheimer's Disease	☐	☐	39.	Chronic Depression	☐	☐
4.	Back/Spinal Disorders	☐	☐	22.	Other Neurological Disorders	☐	☐	40.	Other Mental/Behavioral Disorders	☐	☐
5.	Back Strain/Sprain	☐	☐	23.	Hemophilia	☐	☐	41.	Venereal Disease	☐	☐
6.	Scoliosis	☐	☐	24.	Kidney/Urinary Disorders	☐	☐	42.	Deafness	☐	☐
7.	Spina Bifida	☐	☐	25.	Tumors/Growths	☐	☐	43.	Ulcerative Colitis	☐	☐
8.	Stroke	☐	☐	26.	Juvenile Diabetes	☐	☐	44.	Diverticulitis	☐	☐
9.	Cancer, Leukemia, Melanoma	☐	☐	27.	Diabetes Mellitus	☐	☐	45.	Crohn's Disease	☐	☐
10.	Emphysema	☐	☐	28.	Heart Attack/M.I.	☐	☐	46.	Gastric/peptic Ulcer	☐	☐
11.	Chronic Bronchitis	☐	☐	29.	Coronary Artery Disease	☐	☐	47.	Other Bowel/Stomach Disorders	☐	☐
12.	Asthma	☐	☐	30.	Bypass Surgery	☐	☐	48.	Premature Birth	☐	☐
13.	Other Lung Disorders	☐	☐	31.	Congestive Heart Failure	☐	☐			☐	☐
14.	Liver Disorders	☐	☐	32.	Pacemaker	☐	☐	**Identify any other condition not listed above:**			
15.	Congenital Disease/Defect	☐	☐	33.	Ischemic Heart	☐	☐	49.	Other :		
16.	Paralysis	☐	☐	34.	Other Heart Disorders	☐	☐	50.	Other :		
17.	Multiple Sclerosis	☐	☐	35.	High Blood Pressure	☐	☐	51.	Other :		
18.	Cerebral Palsy	☐	☐	36.	Alcohol or Drug Dependency	☐	☐	52.	Other :		

B. Give complete details regarding any of the conditions to which you answered "YES" or any "other" condition above.

CONDITION NUMBER	PERSON TREATED	TYPE OF TREATMENT	DATES OF TREATMENT From (mo/yr)	To (mo/yr)

C. Are You or any Dependent currently on any prescription medication or have been on any prescription medication in the past 3 years? Yes ☐ No ☐ If "Yes", please complete the following:

PERSON TREATED	MEDICATION	DIAGNOSIS OR CONDITION	DATES OF TREATMENT From (mo/yr)	To (mo/yr)

D. Have You or any Dependent tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? Yes ☐ No ☐

E. Are You or any Dependent now pregnant? Yes ☐ No ☐ If "Yes", what is the due date? _____

If yes, is this pregnancy high risk or complications anticipated? Yes ☐ No ☐ If "Yes", please give patient name and explanation:

_____

_____

F. Have You or any Dependent received abnormal results from any diagnostic test (including but not limited to Blood Test, Urinalysis, EKG, X-ray, Ultrasound) in the last 12 months? Yes ☐ No ☐ If "Yes", please give the patient name, date of service, type of test and results:

_____

_____

G. Have You or any Dependent been advised to have any diagnostic test, medical evaluation, hospitalization or surgery in the next 12 months? Yes ☐ No ☐ If "Yes", please give the patient name, date of service, type of service and reason for the service:

_____

_____

I UNDERSTAND that this information will be used to determine premiums for coverage applied for. I UNDERSTAND that I, or my Dependents may be required to provide additional information regarding any of the above responses, including providing a medical release to obtain medical records. I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge. I UNDERSTAND that if I have made any material false statement, misrepresentation or omission on this form which changes the risk assumed by this plan, I may lose coverage under Health First Health Plans, Inc. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree (under Florida Law Chapter 95-340).

Signature:	Date:

Representative Mark Carter

NOTES FOR TESTIMONY ON SB110
(Small Group Health Ins. Reform)
3/18/03

- Current NH Law of "Community Rating" of groups of up to 100 is overly "Socialistic".

- NH must open the health insurance markets to the competitive process to the greatest extent reasonable in order to help bring rates down.

- 49 states and the District of Columbia define "small group" as 50 or fewer people -
  Two define it as anything larger than 50
  Defining small group as 50 or fewer (2-50) is clearly more than reasonable.

- In 1994 44,000 +/- lives were un-insured in NH. Now 110,000+/- lives are un-insured. Community rating has not passed the test.

- According to testimony before the NH House Commerce Com. from April 7, 1994- NH had the 3rd lowest Health Care rates in the nation.

- According to the org. "New Hampshire for Health Care", NH now has the 12th highest rates in the nation.

- Since 1994 NH's ranking has dropped at least 35 places from the 3rd most affordable state to the 12th most costly state in the nation in which to buy health insurance.

- There is every reason to believe that this dramatic change has been the result of the lack of competition in NH brought about by the "socialistic" approach of our far to broadly defined small group community rating system and every reason to believe that statutory reform can help to return NH to a more appropriate market balance.

- According to the 1994 testimony of then Senator Jeanne Shaheen -" Finally, I think all of the supporters of this bill are concerned about what the potential impact on rates will be when it gets enacted. I view this as an ongoing process".

- In summary, the enactment of the 1994 Small Employer and Individual Insurance legislation was well intended. Time has passed and circumstances have changed. The results may now be analyzed. The 1996 Federal Kennedy-Kasabaum Act has eliminated many issues pertinent in NH in 1994. " Small group" size consensus has been reached all across the U.S. It is time for NH to act again to upgrade/improve health insurance regulation in the State.

Harvard Pilgrim Health Care

INCLUDING
Harvard Community Health Plan
Harvard Pilgrim Health Care of New England
Pilgrim Health Care

TESTIMONY OF BETH ROBERTS
VICE PRESIDENT, NORTHERN NEW ENGLAND OPERATIONS
HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND
BEFORE THE HOUSE COMMERCE COMMITTEE
REGARDING SB 110

APRIL 23, 2003

Good afternoon. My name is Beth Roberts. I am the Vice President of Northern New England Operations for Harvard Pilgrim Health Care of New England. Harvard Pilgrim currently serves over 57,000 New Hampshire residents. Thank you for the opportunity to testify on Senate Bill 110. Like the sponsors of Senate Bill 110 and everyone here today, Harvard Pilgrim is very concerned about the affordability of health care coverage for New Hampshire's small businesses and their employees.

In recent years, health care costs have been rising faster than inflation in general. Health care costs are being driven by a number of factors, including increased utilization, higher fees charged by doctors and hospitals, new drugs and medical technologies, an aging population and government mandates. These cost increases have coincided with a slowdown in the economy, making them more difficult for employers to absorb into their operating costs. This is particularly true for small employers.

Most employers have responded to these trends by either increasing the amount that employees are required to contribute toward their coverage or by selecting plans which cover fewer benefits or which require higher co-payments at the point of service. Some employers face the difficult decision of whether they can continue to offer any coverage at all. Even when coverage is offered, some employees find that they cannot afford to pay their share of the premium.

Harvard Pilgrim has tried to be responsive to employer needs by developing more affordable product options, such as our *Best Buy* plan and our new *NetOption NH* plan. We've designed these products with several goals in mind – offering coverage for a lower premium, maintaining access to primary and preventive care, and encouraging consumers to be more involved in their health care decisions. Our *Best Buy* product features an annual deductible for many services, enabling us to offer coverage at a lower premium than our traditional HMO plans. Consistent with our historical focus on preventive care, physician office visits and many preventive screening tests, such as mammograms, are not subject to the deductible. Under our new *NetOption NH* product, patients choosing to receive certain types of care at participating Massachusetts specialty hospitals will pay more for that care than they would at New Hampshire hospitals. Again, this will allow us to offer a more affordable product while maintaining choice.

Senate Bill 110 offers the Legislature an opportunity to do its part to make coverage more affordable. Among other things, Senate Bill 110 would redefine small group to include only those groups with 1 to 50 employees. Harvard Pilgrim supports this change. Groups with 51 to 100 employees have different needs than very small groups both in terms of the type of coverage desired and the ability to pay for that coverage. This change would allow health plans to offer different products to different sized groups that better reflect their needs and ability to pay.

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Senate Bill 110 would also give health plans greater flexibility in setting rates based on age. Harvard Pilgrim supports this change. In general, younger individuals are less able to afford health insurance and are expected to use fewer health services. Consequently, younger employees are more likely than other employees to decline coverage when their employer offers it. Widening the permissible age bands would result in lower rates for groups with younger employees and, in turn, a lower employee contribution towards that coverage. This could help to increase the number of younger employees who choose to purchase the coverage offered by their employer. While this would also result in higher rates for older groups in the short term, bringing more younger individuals into the risk pool should help to stabilize rates over the long term.

While Harvard Pilgrim supports these two changes to the small group law, we have a number of concerns about the provisions in Senate Bill 110 that would allow insurers to vary premium rates charged to small groups based on the health status of the members of the group. This would be a significant change to the small group market, and Harvard Pilgrim believes that it should not be enacted until the Legislature conducts a more thorough study on the impact that this would have on New Hampshire's small businesses and their employees. The issues that should be explored include:

- Whether the proposed changes to the group size definition and to the age bands are sufficient to meet our goal of a more stable and affordable small group market or whether further legislative changes, such as re-introducing medical underwriting, are necessary?
- Will the re-introduction of medical underwriting into the small group market have a positive or negative impact on the number of people without insurance in New Hampshire?
- How do we ensure that less healthy individuals are adequately protected from employment discrimination?
- What impact will medical underwriting have on administrative costs?
- What can we learn from other states that allow medical underwriting and from states that have tried other approaches to improving affordability for small groups?

Harvard Pilgrim stands ready to work with the Legislature and other interested parties to reach consensus on these important issues. In the meantime, we urge the Legislature to enact the proposed changes to the group size definition and to the age bands. These two changes would be an important step towards a healthier and more affordable health insurance market.

Before I conclude, I would like to make one final point. As currently drafted, this legislation would take effect on July 1, which is less than 3 months away. Given the magnitude of change that is being proposed, we would ask that the effective date of this legislation be no earlier than January 1. This would give insurers adequate time to modify their rating practices in accordance with the legislation and to communicate with their customers about these changes.

Thank you for your consideration. I would be happy to answer any questions about Harvard Pilgrim's position on this legislation.

Kenneth Chapman

u.s. Chairperson, members of committee

Thank you for allowing me to be here today. My name is Ken Chapman and I am one of the owner/managers of the Kancamagus Country Store in Lincoln. I am a resident of Woodstock.

Our business is now in its 20th year. From the very beginning, our philosophy has been to share with our employees by providing benefits. We offer health, dental, and 401(k) and profit sharing plans. Many of our employees have been with us many years.

That has created a problem for us. Each year as our health insurance costs have risen, the healthier, younger staff members have said they would risk not having health insurance. They preferred to have more cash in their pockets. What remains is an older unbalanced look to our health group. since we cannot require participation

This is the main problem I see with SB110—in its current form. It allows each group, regardless of size or composition, to be rated on its own census. Present law has groups such as ours rated on age, but not health.

To look at our group now, you would think that the north country is made up of aging single women, with one aging solitary male (me).

We took a major jump in rates this year. My own cost is now ~~$140~~ per ~~week~~. Our employees (who are paid between $8 and $9 per hour) pay a share that totals $62 per week. In other words, they must pay one-day's pay to have health insurance each week. It is hard selling coke and chips to pay employees more.

A plan that looks at the health of this specific group would be devastating. It is bad enough that it looks at the average age of our group and not the average age of the larger community. ~~to~~ Regional Carriers to that state in which. To offer products state-wide

I do not believe that more carriers will flood the north country market. Each year when we get quotes, it boils down to two, Anthem and Cigna. However, I had to change hospitals when we were with Cigna, because Littleton Hospital chose not to participate in the plan that we had with Cigna.

This is the problem with this bill: it further will separate this great state and its population into the affluent south, and the poor rural north. We already have fewer choices; please do not allow a law that will further isolate and impoverish the people of the beautiful north country.

Bob Cranage.
Morrell Corp.

SB 110

Some Perspective: I am 60-year-old male, working with 40 other full time employees in Carroll County. I am here representing my employer, the Morrell Corporation, located in Glen NH. The Company is in the tourist attraction industry. Our district's representative is Mr. Chandler. We are one of Carroll County has 1850 business. 1804 of our county's businesses have less than 50 employees. The Morrell supports the goals of this legislation, but can't support this legislation in its current form. The following elements taken as a whole will have a catastrophic impact on our employees and our Company.

1. ***Community rates*** shall be established by each health carrier for all health coverage offered to individuals and, separately, for all of its health coverage offered to small employers. ***All premiums shall be guaranteed for 6 months.***

Each small business will be rated based on its community membership. This is a 180-degree shift from current practice that does not utilize community rating of the current population of small business (1-100). Small businesses will incur increases in premiums and operational costs, as the small businesses' health history will be the most significant element of that business's new rated health premium. A few insurable but highly rated employees would skew the small businessman's health premium cost to a level that could lead the small business to not provide health benefits at all. There is nothing to interest or compel the newly arrived health insurance providers to gamble on a small business pool that contains high-risk employees.

2. Establishes that health carriers providing coverage to individuals shall calculate a rate that is derived from the health coverage base rate through the application of rating factors that carriers choose to utilize based on age, health status, and tobacco use. Such factors may be used in accordance with the following limitation:

A. The maximum premium differential for age as determined by ratio is 4-1 this limitation shall not apply for determining rates for an attained age less than 19.

B. The maximum differential due to health status shall be ***1.5-1.***

SB 110 expands the allowable rating to 4-1, from the current ratio of 3-1, there is a permissible health rating up to a ratio of 1.5 times the base rate for the employee population with health issues. Under current law there is not an indexing of those employees with health issues. The cost of insuring any small business with 55 to 64 years olds will significantly rise. Nine percent of NH's population is between 55 and 64. Remember there are 1805 small employers in Carroll County. How well can a small business of 10 in the North Country spread the 55-64 years old person's risk around within their pool? It is interesting to note that the average age of those in the Machine Tool Trade in NH is 62 years of age. As you know these shops are already hard pressed to find new tradesmen.

3. Carriers may use the employers' small group industry classification as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 20%.

Carriers may use the employers' small group geographic location as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 15%.

Carriers may use the employers' small group as a rating factor. However, the application of the health factor shall be subject to the following limitations:

(A) The health status factor may reflect health status of covered persons, the small employer's experience, or the duration of coverage since health statements were last provided.

(B) Variations from the arithmetic average of the highest rate charged to the lowest rate charged shall not exceed 25 percent.

(C) Upon renewal of a small employer policy, any increase in the premium rate is solely attributable to changes in the health status factor from the prior year shall be no more than 15%.

Although these percentage limitations on premium increases due to employee health status are intended to control the premium cost of the small employer, they can be added on to other increases caused by factors included in this legislation. Geographic region and certain SIC codes can bump up the small employers' premiums. Costs due to the medical trend factor are permitted over and above the defined categorical increases.

Under current law none of these factors are in place for small businesses. Only medical trend factors and the employees' current age are considered when the health carrier calculates the small businesses new health premiums.

The BIA insurance committee report appears recognize the North Country as a geographical region that will be rated. They also concur that the SIC codes most frequently identified by health insurance providers are at the heart of the North Country businesses.

4. Upon the renewal of a small business policy, a carrier is prohibited from increasing the premium rate by more than 15% of the rate that was charged the preceding year. Such rate increase limitation shall not include any premium rate increases that are based on the carrier's annual cost and utilization trends; changes in the rating factor for group sizes; or changes in the rating factor for attainable age of the covered persons. This subparagraph shall expire January 1, 2005.

Current health insurance providers' costs are averaging between 13 and 18% a year. Even with this cap provision, the increase for small business health premium costs could increase by at least 40% or more. This cap provision is removed after

January 1, 2005. If health carrier competition does increase, insurance carriers will not be restricted from "cherry picking" the best small businesses. They may then chose to not quote, or heavily burden the higher risk North Country small businesses. As this legislation would barely be in effect by the end of 2003. We perceive a one-year ramp up to be very quick.

5. Health carriers providing health coverage for individuals or small employer groups may perform medical underwriting, including the use of statements, screenings, or the use of prior claims history to the extent necessary to establish or modify premium rates as provided in RSA 420-G: 4. The commissioner may by rule, require a standardized health statement.

Should this legislation be enacted, there will be a need for some process for non-current providers to review small business employee membership and quote rates. This is a substantial change from current practice, and small employers would be best served by one standard questionnaire that would be used by all health carriers. That one form could be circulated to the many new insurance providers. This would minimize the paperwork for small businesses that are already deluged with paperwork.

The Morrell Corporation benefit package has been very sensitive to the needs of our employees, and the increase costs associated with providing their benefits. Recently we have had success at offering more restrictive, but less costly health insurance plans to our employees. We have also contributed to their 125 flexible benefit plan to offset some of the increases in their co-pays and deductibles. The Company has kept our health related insurance cost relatively stable. We continue to pursue approaches to improve our employees' wellness, and utilize recent federal tax relief legislation to stabilize our benefit costs. We have recently implemented a 125-program flex card to minimize our employees' paperwork, and speed provider payments. With all our planning, we are now facing a radical shift in public policy with a very brief ramp up and transition timeline.

While we are strong proponents of a Free Market System where competition is encouraged, we perceive that the passage of this particular legislation, if passed in its current form, will have a negative impact for a very large segment of New Hampshire's small businesses. This legislation, by design, will particularly impact those in the North Country.

We encourage this committee to amend this legislation to balance the drive for more competition in the health insurance industry with elements that will be fairer to the small businesses of the North Country.

Thank you for your consideration of this very complex issue.

Bob Cranage
The Morrell Corporation
Box 1776
Glen, NH 03836
603-383-4293

SOUHEGAN WOOD PRODUCTS, INC.

Ten Souhegan Street P.O. Box 120 Wilton, New Hampshire 03086 USA Tel. (603) 654-2311 FAX (603) 654-6631

IN OPPOSITION TO SB110
An Act Relative to Small Group Health Insurance Coverage

Testimony to House Commerce Committee, April 23, 2003
submitted by Elizabeth Dunn, Vice President
Souhegan Wood Products, Inc
Wilton, NH

The purpose of insurance is to spread risks over a large group of people and then pool resources to cover an individual loss. This is a longstanding principle that everyone understands but seems to be hard to put into practice, except in specific cases like the old New England tradition of barnraising after a fire. Perhaps the real difficulty lies in the different agendas of the people you will hear from today. The insurance industry is pursuing profits at the least possible cost which, as a business owner, I understand. There is, however, the other equally important goal which is giving the buyer real value for their money, not a promise of health care benefits that disappear with time and adversity.

There are two features of SB110 which seem especially harmful, not only to the underlying principle of insurance but also to the long term public policy goal of ensuring that people can pay for their health care costs when they need to. First of all SB110 would decrease the size of the risk sharing pool by defining small groups as those of only 1 to 50 people, or exactly half of the current size of 1 to 100. This decrease in the size of the risk pool is further exacerbated by subdividing the proposed small group pool into geographic and industry subgroups. Finally, the provision in SB110 for medical underwriting destroys the true meaning of community rating, leaving the insurance industry virtually free to charge whatever they want to each individual group.

This is tantamount to saying that every small group is self-insured. Community rating made its debut on January 1, 1995 in response to just that scenario which had created an irrational health insurance market that kept the brokers in a constant frenzy of cherry picking. I will never forget the months preceding that date when our mail, our phones and our office were all full of insurance agents eager to find out the health of our employees.

Furthermore, SB110 gives small groups no access to their individual group's loss runs. Without them there is no opportunity to correct inevitable errors which, with medical underwriting, would adversely affect the premium charged. For example, I know from long experience with our company's workers compensation insurance that review of the loss runs is essential to keeping our insurer's record accurate and our premium down.

Community rating was the first small, crucial step to rationalize the health insurance market and SB110 would destroy that gain. Everyone is young once. Everyone ages. Everyone gets sick at some point in their alloted time on earth. If SB110 passes it will again give a hunting license to the health insurance industry to take money from the healthy only to refuse to insure them or surcharge them usurious rates when they become sick.

I am sure that the proponents of SB110 will tell you that they can insure more people should the bill pass. That claim may be true if the definition of insureds means the number of people paying premiums but will be false if the definition means the number of people able to pay for health care when they need it. The public good is best served when health insurance pays for people's health care rather than abandon them to the free-care pool and the heavy social costs associated with it. I urge this committee to give SB110 an ITL report.

Granite State
Independent Living

"Promoting Life with Independence for People with Disabilities"

Granite State Independent Living

Testimony SB 110
House Commerce Committee
April 23, 2003

Mr. Chairmen members of the committee, my name is Clyde Terry and I am the director of Granite State Independent Living. I am here today to speak in opposition to SB 110 as it will have a devastating effect on large numbers of New Hampshire citizens with health care needs and disabilities and on my organization in particular.

First I want to point out that having a disability or a serious health condition is not about someone else it truly is about you, members of your family, your neighbors and your constituents. According to the latest census one in nine children has a disability, one in five adults between the age of 18 and 64 and one in two over the age of 65. So to construct a health insurance system under the guise that someone else is going to pay more is misleading and misguided. Because the truth is we can not run away from illness or disability as it is part of the normal life experience. And being healthy is only a temporary condition. While this reality is not popular it is none the less the reality.

This bill constructs a system to penalize those who become ill or suffer a disability and places them and their families at greater risk economically when they are already reeling from a looming diagnosis cancer, hearth disease or worse. Ultimately this bill will not save money for you constituents it will cost them more. While the existing system may not be perfect, this alternative is too risky.
A further unintended consequence of this legislation will be to create a disincentive to employers to hire persons with disabilities or to retain a person who experiences a serious health condition. This will lead to larger demands on financial and social services in the state, county and local budgets.

The second point I need to raise with you is the devastating effect this legislation will have on Granite State Independent Living. We are a state-wide organization that provides a variety of services to persons with disabilities and the elderly. What makes us unique is that we are required by federal law to employ the majority of my workforce are persons with disabilities. We, just like everyone else is experiencing the rise in health premiums the consequences of this legislation will however be disastrous. Whether defined as a large group or the small group the inclusion of health status will result in a reduction in work force or services, if I argue to be included the bill the consequences are the same. In your deliberations I urge you to keep community rating so that you do not do harm. Members of the committee community rating works, I urge you to reject this proposal until you have considered all of the unintended consequences. Thank you.

CURRENT BENEFIT

Anthem BCBS

Health Proposal

Sir Speedy Printing - Manchester
41 Elm St
Manchester, NH 03101

Effective Date: 05/01/2003 (R)
Proposal Number: 03553064601
Corporation ID: 9503
Division ID: 0090450001
BCBS/MTHP Rep: Tina Daniels

Contract Description: B3S02 - BlueChoice 3-Tier
$10 OV $50 ER 100% IP/OP Dental Rider $5/$15/$25 w/Mail PD to $5000 Chiro Rider

Name	DOB	Sex	Coverage Type	Monthly Premium
Stockbridge, Heather L	12/20/1969	F	S	$273.49
Stonner, Jason A	03/01/1969	M	F	$950.30
Glidden, William C	03/02/1962	M	S	$302.82
Stonner, Doreen K	05/20/1947	F	C	$1,403.70
Total Monthly Premium:				$2,930.31

X 12
35,163.72
25%

Disclosure of Rating and Renewability Provision
For Community Rated Groups

**** The above rates are subject to approval by the N.H. Insurance Department. ****

The rates for this coverage are determined by the age of the participants as well as the type of membership and benefit design chosen. Rates are not based upon a group's own experience, health status or duration of coverage. Coverage is renewable except for: nonpayment of premium; fraud or intentional misrepresentation on the part of an employer, employee, dependent or an employee's representative; failure to meet the minimum employee participation requirement; the employer is no longer actively engaged in the business that it was engaged in on the effective date of coverage; the employer medically underwrites or otherwise violates a provision of NH RSA 420-G; or Anthem BCBS ceases to offer health coverage to this market segment. The rating and other practices are in compliance with New Hampshire law RSA 420-G.

Underwriting Disclosure

No coverage in this proposal/renewal shall go into effect until the Underwriting requirements have been met. The proposed rates are based upon the enrollment as of the date this proposal/renewal was generated. If the final enrollment changes by more than 10%, we reserve the right to rerate. If the final census does not meet the minimum employee participation requirement we reserve the right not to offer coverage.

How many total benefit eligible employees does your company have? _____

Is your company part of a subsidary or a branch of a parent company with more than 100 employees? ☐ *Yes* ☐ *No*

If YES, do New Hampshire employees have access to a medical plan sponsored by the parent company? ☐ *Yes* ☐ *No*

Do you offer your employees another health plan? ☐ *Yes* ☐ *No*

If YES, please identify other plan _____

Group Signature: (Y) _____ *Date:* _____

Do you have a Broker? ☐ *Yes* ☐ *No*

Broker Signature (if nec): _____ *Date:* _____

[redacted]

Anthem

3000 Goffs Falls Road
Manchester NH 03111-0001

000952010101

Customer Service 1-800-273-2521
1-603-695-7000
Hearing Impaired (TDD) 1-800-499-2865
Visit our web site at www.bcbsnh.com

#BWNCQXF
#9999999990000NJ2#
MS. DOREEN STONNER
SIR SPEEDY PRINTING-MANC
41 ELM ST
MANCHESTER NH 03101-2719

INVOICE DATE 02/11/2003
CUSTOMER NUMBER D 009045-0001
INVOICE NUMBER 00010125-1244
BILLING PERIOD 03/01/2003 - 03/31/2003
DUE DATE 03/01/2003

CURRENT BILLING

CERTIFICATE	SUBSCRIBER NAME		BIRTH DATE	SEX	ADJUSTMENT PERIOD	TYPE/ CLASS	DESCRIPTION	AMOUNT	TOTAL
001507318	GLIDDEN	WILLIAM C	03/02/1962	M		Single	HEALTH	$277.36	$277.36
001609704	STOCKBRIDGE	HEATHER L	12/20/1969	F		Single	HEALTH	$250.38	$250.38
002346620	STONNER	DOREEN K	05/20/1947	F		Couple	HEALTH	$997.91	$997.91
002686962	STONNER	JASON A	03/01/1969	M		Family	HEALTH	$863.58	$863.58

SUMMARY (ACCOUNT NUMBER 009045-0001)

		Single	Couple	P/C	Family
PREVIOUS AMOUNT DUE	$2,389.23				
PAYMENTS RECEIVED	$2,389.23CR				
CURRENT BILLING					
HEALTH	$2,389.23	2	1		1
HEALTH ADJUSTMENTS	$0.00				
CURRENT TOTAL	$2,389.23				
TOTAL AMOUNT DUE	$2,389.23				

X12= 28,670.76

DATE OF LAST PAYMENT 02/05/2003

(PAYMENTS/ADJUSTMENTS PROCESSED AFTER 02/11/2003 WILL BE REFLECTED ON YOUR NEXT INVOICE)

anthem.

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

1000 Goffs Falls Road, Manchester, NH 03111-0001

Customer Service 1-800-438-9672
1-603-695-7000
Hearing Impaired (TDD) 1-800-499-2865
Visit our web site at www.bcbsnh.com

DOREEN STONNER
SIR SPEEDY PRINTING- MAN
41 ELM ST
MANCHESTER NH 03101

INVOICE DATE 08/11/2000
CUSTOMER NUMBER D 009045-0001
INVOICE NUMBER 00010035-7838
BILLING PERIOD 09/01/2000 - 09/30/2000
DUE DATE 09/01/2000

CERTIFICATE	SUBSCRIBER NAME		BIRTH DATE	SEX	ADJUSTMENT PERIOD	TYPE/ CLASS	DESCRIPTION	AMOUNT	TOTAL
CURRENT BILLING									
014544546	MAGLIO	STEPHEN L	07/16/1959	M		Single	HEALTH	$263.54	$263.54
226134611	PARADIS	LORETTA L	08/22/1972	F		Single	HEALTH	$190.73	$190.73
002346620	STONNER	DOREEN K	05/20/1947	F		Couple	HEALTH	$718.06	$718.06
002686962	STONNER	JASON A	03/01/1969	M		Couple	HEALTH	$406.90	$406.90
003647840	TASK JR	WILLIAM F	01/26/1967	M		Single	HEALTH	$203.45	$203.45

SUMMARY (ACCOUNT NUMBER 009045-0001)

		Single	Couple	P/C	Family
PREVIOUS AMOUNT DUE	$1,782.68				
PAYMENTS RECEIVED	$1,782.68CR				
CURRENT BILLING					
HEALTH	$1,782.68	3	2		
HEALTH ADJUSTMENTS	$0.00				
CURRENT TOTAL	$1,782.68				
TOTAL AMOUNT DUE	$1,782.68				

X12 = 21,392.16

DATE OF LAST PAYMENT 08/07/2000

(PAYMENTS/ADJUSTMENTS PROCESSED AFTER 08/11/2000 WILL BE REFLECTED ON YOUR NEXT INVOICE)

SMALL GROUP PREMIUM STATEMENT

YOUR RECORD

GROUP NUMBER	PREMIUM DUE			PAYS GROUP TO		
	MO.	DAY	YR.	MO.	DAY	YR.
61Y6	FEB	01	95	MAR	01	95

ITEMS RECEIVED AFTER JAN 09 95 ARE NOT INCLUDED

To prevent termination of your group insurance as of the above due date, the premium must be paid within 31 days.

SIR SPEEDY PRINTING CENTER
41 ELM STREET
MANCHESTER NH 03101

MGR CON GRACE DIVISION OFFIC
AGT WILLIAM NALETTE
AGT

NAME OF EMPLOYEE	CERT #	EFFECTIVE DATE	CLASS	# OF DEPS.	LIFE VOLUME	LIFE PREMIUM	H & A PREMIUM	TOTAL PREMIUM
TOTAL AMOUNT DUE LAST BILL								1409.1
TOTAL PAYMENTS RECEIVED								732.2
BALANCE LAST BILL								676.8
PREVIOUS ADJUSTMENTS*								
CHARGES								
STONNER, RICHARD C								
EMP REM CANC EFF01 01 95	00400	12 01 92	1D	0		.23	55.09	55.32
TOTAL CHARGES								55.32
CURRENT MONTH CHARGES								
BREWER, RICHARD A	00500	01 01 94	3	0	15000	7.20	123.05	130.25
LABRECQUE, TRACEY	00600	12 01 94	3	0	15000	7.20	123.05	130.25
STONNER, DOREEN K	00200	12 01 92	1	0	25000	12.00	128.95	140.95
STONNER, JASON A	00300	12 01 92	2	0	15000	7.20	127.29	134.49
STONNER, RICHARD C	00400	12 01 92	1D	1	25000	12.23	184.04	196.27
TOTAL CURRENT CHARGES								732.21
								X12
IT IS IMPERATIVE THAT WE RECEIVE APPLICATIONS AT THE HOME OFFICE FOR NEW EMPLOYEE AND/OR DEPENDENTS PRIOR TO THEIR ELIGIBILITY DATE. IF AN APPLICATION IS RECEIVED AFTER THIS DATE, THE APPLICANT WILL BE TREATED AS A LATE ENROLLEE.								
								8786.52

IMPORTANT INSTRUCTIONS

(1) Line out names of employees no longer eligible and indicate date last worked on all copies of billing. COMPLETE CERTIFICATE ADJUSTMENT CARD FOR EACH TERMINATION.

(2) Deduct premium for terminated employees and/or dependents from the TOTAL AMOUNT DUE.

(3) Return the #2 copy with your payment.

(4) For supplies needed--see administration kit for order form.

(5) **VERIFY ACCURACY OF INDIVIDUAL INFORMATION EACH MONTH. NOTIFY HOME OFFICE IMMEDIATELY OF ANY DISCREPANCIES AS CREDITS CANNOT EXCEED 60 DAYS.**

(6) Written notification of any intent to cancel is required by the contract. Please submit written statement to request the termination of this plan.

CO. 2 SERIES 1A

GROUP # 61Y6-8

DEPOSIT

CHECK #

AMOUNT

B4 1

UNITED OF OMAHA

78753

TOTAL AMOUNT DUE $ ~~1464.42~~

SMALL GROUP CUSTOMER SERVICE
MUTUAL OF OMAHA PLAZA
OMAHA, NE 68175

GROUP: *SIR SPEEDY PRINTING
EFFECTIVE DATE: 94/06/01

POLICY NUMBER SECU 61Y6
STATE CODE--NH

PLAN SUMMARY

ASS	LIFE VOLUME	DEP LIFE VOLUME	AD&D VOLUME	DISABILITY INCOME 00-ACC /07-SIC 26 WEEKS WEEKLY BENEFIT	MAJOR MEDICAL W/O MAT DEDUCTIBLE	WITH SUPP COIN	ACC OUT-OF POCKET	DENTAL DEDUCT
)								
1	25	2	25	320	150	80/20	500	0
2	15	2	15	300	150	80/20	500	0
3	15	2	15	220	150	80/20	500	0

LIFE VOLUME: 81,000
LIFE RATE WITHOUT AD&D 0.48
DEPENDENT LIFE RATE: SPOUSE 0.90
CHILDREN 0.23

AD&D VOLUME: 80,000
CERTIFICATEHOLDER AVERAGE AGE: 37.0

MANDATED MENTAL/NERVOUS: N

C E R T I F I C A T E H O L D E R S :

EMPLOYEE LF	AGE	SEX	MC	SPOUSE AGE	MC	# CL CH	ID	NUM	EMPLOYEE LF	AGE	SEX	MC	SPOUSE AGE	MC	# CL CH	ID
25	47	M	N	0		0	1	003	15	25	M	N	0		0	2
15	29	M	N	0		0	3									

NUM	EMPLOYEE LF	AGE	SEX	MC	SPOUSE AGE	MC	# CL CH	ID
004	25	49	M	N	0		1	1

	LIFE	DISABILITY INCOME	OTHER H&A	TOTAL PREMIUM
MONTHLY GROUP PREMIUM:	38.63	63.80	515.93	618.36
	LIFE		H&A	x12
ANNUAL GROUP PREMIUMS:	463.56		6,956.76	7420.32

IING--FACTORS CALCULATED USING CURRENT CENSUS--CHECK FOR ACCURACY

RUN DATE: 03/15/94 MC - DENOTES MEDICARE

Mutual of Omaha Companies

03/15/94

RE: Renewal SECU-61Y6

SIR SPEEDY PRINTING
CENTER
41 ELM STREET
MANCHESTER NH 03101

Dear Employer,

Periodically, we review the costs associated with group insurance. This review takes into consideration a number of factors such as inflation, claims payments, age changes within your group, dependent status changes and the experience of our entire block of Small Group business.

As a result of this review, we find it necessary to adjust your current monthly premium to $ 618.36 effective 06/01/94 . The enclosed Premium Adjustment Rider indicates your new rates by category. Also, please keep in mind that periodically we recalculate the average age of the individuals insured in your group to determine the appropriate premium for your plan of benefits. The enclosed plan summary page provides you with the information used in that recalculation.

At the bottom of this letter, we have listed a number of deductible options you may elect to reduce your monthly cost. Should you choose to select one of these deductible options simply sign and date the letter, indicate the deductible option you wish your group to have and return a copy of the letter to us as your authorization for us to make the change. The new deductible and premium will be effective with the first billing period following our receipt of your request. If you choose to maintain the same benefits you now have, you need not do anything at this time.

We at UNITED OF OMAHA take pride in providing quality insurance protection in today's changing times. We certainly appreciate your continued trust and confidence.

Sincerely,

John T Green

John T. Green
Second Vice President & Director
Small Group Underwriting & Administration

I authorize the change in deductible to that indicated below:
(Please circle one)

Ded:	$250.00	$500.00	$1,000.00	$2,000.00
*Premium:	$595.71	$554.23	$498.26	$425.28

Name _____ Date _____

_____
Signature

*Based on the census indicated on the enclosed plan summary

CC: B4
ATTN: WILLIAM NALETT
CON GRACE DIVISION OFFIC

United of Omaha Life Insurance Company

Testimony to be delivered before the NH House of Representatives
Commerce Committee
On Senate Bill 110

Mr. Chairman: My name is Marge McClellan. I am a resident of Berlin in Coos County. I am speaking to you today on behalf of the members Berlin Area Health Consortium, the Berlin/Gorham Concerned Community Providers, the North Country Health Consortium and all citizens of the North Country who either own or work for the area's small businesses. We are greatly concerned that we are going to lose our ability to purchase health insurance -- insurance which is expensive now but will be prohibitively expensive if Senate Bill 110 passes the legislature and is signed unto law. To put our concerns into perspective, you should know that 75 percent of Coos County employers have 50 or fewer employees. Forty-one percent have between one and four employees.

As I understand it, SB 110 will change the way health insurers calculate rates for the small group health insurance market by allowing factors such as geography, age, health status, and type of business to guide the calculations. While it is true that in the Southern part of the state these changes might attract more insurers to the market, analysis of the bill from several sectors has concluded that passage of SB 110 could have profound negative effects for the North Country citizens.

Currently, almost half of Coos County employers are not able to offer their employees health insurance. With weekly wages of less than $500, most Coos County residents cannot afford to purchase health insurance themselves. In the existing market, premiums can cost over $750 per month for family coverage, depending on age, health risk factors and plan availability.

I would like to offer some additional information about the population of Coos County and how SB 110 could affect us. *(I might add that these data have been collected from*

information supplied by Anthem Blue Cross, the Business and Industry Association and the NH Department of Employment Security.)

- Almost 12 percent of the Coos County population is between the ages of 55 and 64 compared with a figure for the state of less than nine percent. **(Workers aged 60 and over could have their premiums increased by almost 14 percent with passage of SB 110.)**
- Almost 18 percent of the Coos County population is 65 or over. The figure for the state is 12 percent. **(Workers over the age of 65 could have their premiums increased by over 25 percent.)**
- Although data on health status are hard to obtain, it appears that rates of obesity, hypertension and coronary artery disease are higher in Coos County than for the rest of the state. **(Workers indicating such conditions could have their premiums increase by up to 25 %.)**
- Almost 32 percent of Coos County residents work in service industries which include health care, tourism, auto repair, etc. Another 20 percent work in construction and manufacturing. **(Workers employed in these trades could see their premiums increase by up to 20 percent with passage of SB 110.)**

In sum, small employers that trigger all the factors delineated in SB 110 could see their premiums increase by over 90 percent.

Currently Coos County relies on safety net providers to meet its health care needs. These safety net providers supply care regardless of ability to pay. If even more of Coos County citizens lose access to health insurance and become self pay patients, Coos County health care providers will face financial collapse and patients will go without care. According to a recent report from the National Institute of Medicine, "adults under the age of 65 [without health insurance] . . . face a 25 percent higher risk of dying than those with private insurance. This

pattern is found when comparing deaths of uninsured and insured patients from heart attack, cancer, traumatic injury and HIV infection."

On behalf of all North Country citizens who risk losing their health insurance with passage of SB 110, I urge you, in fact I plead with you, not to support passage of SB 110. I know it sounds overly dramatic but, literally, lives are at stake.

Thank you.

C.I.M.
Industries
Inc.

23 ELM STREET, PETERBOROUGH, NEW HAMPSHIRE 03458 / PH: 603-924-9481 / FAX: 603-924-9482

Senate Bill 110 April 23, 2003

Good Afternoon Ladies and Gentlemen and Mr. Chairmen.

My name is Gene Scribner and I am the president of C.I.M. Industries, Inc. in Peterborough, NH. I am also one of the founders of the NHHTC and a member of the Board of Directors.

I am here to testify on behalf of both the NHHTC and my company in respect to the cost of Health Insurance and Senate Bill 110.

My Company has seen its rates for Health Insurance increase by 89.8% for a singles, 95.8% for couples and 109.1% for families for the period 1999 to 2003 (4 years). This is an average of almost 25% per year.

We believe along with many other HTC that something must change since we cannot afford 25% increase if we are to continue in business.

The NHHTC sent a letter to all representatives on April 18, 2003 in respect to the Senate Bill 110, which I would like to highlight at this time.

I would call to your attention to paragraphs 1,2,5,6,7,8,9 and 10.



NEW HAMPSHIRE HIGH TECHNOLOGY COUNCIL

28 Grove Street
Peterborough, NH
03458
(603) 924-8324
FAX: (603) 924-8312

E-mail:
info@nhhtc.org

URL:
www.nhhtc.org

April 18, 2003

Dear Representative:

The New Hampshire House of Representatives will soon be considering Senate Bill 110 which has been passed by the Senate and is designed to lower health insurance costs for small business in New Hampshire. New Hampshire's small businesses currently pay the 2nd highest cost for family health coverage and the 7th highest single employee costs in the United States. Small businesses and small technology businesses in New Hampshire have seen their health insurance premiums sky rocket and for many it is becoming a terrible burden. New Hampshire High Technology Council ("NHHTC") is concerned about the burdening costs of health care for small technology based business in New Hampshire.

NHHTC has a current membership of approximately 225 technology based companies and service providers and its members employ approximately 25,000 New Hampshire employees in well paying technology related or service provider positions.

NHHTC's purpose is to encourage the development and success of technology based business in New Hampshire. It is one of New Hampshire's most vibrant business organizations and is solely dedicated to technology based companies and those companies and individuals who serve them. NHHTC provides its members with industrial advocacy, including, its now well-known Entrepreneur of the Year Award Dinner, its participation in legislative affairs at the state and national level through its Legislative Affairs Committee, its work with the Governor's Trade Missions and various other high tech initiatives concentrated in the State of New Hampshire.

NHHTC through its Legislative Liaison Committee and its Board of Directors is actively involved in working with the New Hampshire Legislature to attempt to structure solutions to the problems faced by small technology based business.

NHHTC believes that Senate Bill 110 could pay an important role in lowering health insurance costs for small New Hampshire technology based businesses. However, in order to provide such assistance Senate Bill 110 needs to be amended so that it includes the following points:

1. The SIC and Geographical location rate factor provisions as currently written in Senate Bill 110 will have an adverse impact on some small businesses. Senate Bill 110 should be amended to allow insurers to have the flexibility to use the geographical location and SIC codes as rating factors to lower rates but not to increase them;

2. Medical underwriting for groups of 1 to 50 as defined in Senate Bill 110 needs to be amended to insure that a standard employee medical questionnaire is developed for all insurers in order to insure equal opportunity in underwriting for insurance providers;

3. Senate Bill 110 should provide that if an insurer offers a competitive health insurance product to 50+ employee groups the insurer must be required to be a competitive player in the 1 to 50 health groups as this latter market represents 90% of New Hampshire small businesses; and such a requirement will reduce the likelihood that insurers providing health insurance in New Hampshire chose to only do business with the 50+ larger health groups;

4. Senate Bill 110 should include safeguards for existing 50 to 100 insurance groups from the adverse affects of premium increases and, therefore, Senate Bill 110 should require that insurers currently insuring those groups not be allowed to increase their premium rates more than 20% to 25% per year over the next 4 years.

If the House of Representative makes the above changes to Senate Bill 110 then the NHHTC requests you to support the Bill, as amended, and to pass it.

Yours very truly,

NEW HAMPSHIRE HIGH TECHNOLOGY
COUNCIL

By: Gene Scribner, President -
CIM Industries, NHHTC
Vice President and Co-Chair
of NHHTC Legislative Liaison
Committee

By: John R. Monson,
Wiggin & Nourie, P.A. and
Co-Chair of NHHTC Legislative
Liaison Committee

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April 23, 2003
Crescentia True

Good afternoon. My name is Crescentia True. I live in Durham and am co-owner of a small business in Manchester. I have 2 daughters ages 9 and 11. I am the primary income provider for my family and I have been for 10 years. I am also a cancer survivor, having completed my second round of treatment just 2 weeks ago.

I am not here on behalf of any Insurance company, insurance broker, insurance underwriter or special interest group. I am here to testify on behalf of people like myself – as an individual consumer.

I am very concerned about the impact the proposed legislation in SB110 will have on small employers. As I understand it, the people who need comprehensive health insurance the most will have to pay more to have it. I think you would agree that no matter what size company one is working for – if any at all, every single individual needs and deserves affordable, comprehensive health insurance. Both our state and nation should be striving to provide just that. But this bill seems to go against that very principle.

I am a partner of a 2-person firm. I pay $811 per month for my family's insurance, or $9,732 for one year. Under this legislation, I could face up to a 25% increase in my premium because of my health status – and so could my business partner, who happens to have a very favorable health status. This would increase my monthly premium by $203 brining it to $1,014, or $12,164 per year. This is higher than the mortgage I pay on my home and I haven't even factored in the annual rate increase based on costs and trends. If this legislation passes in its current form, I could face an increase of just about $4,000 in a single year. I can't even bear to examine what the year after, or the year after that, or the year after that might bring.

I understand that one of the motivations behind this legislation is to increase health insurance competition in New Hampshire. I don't believe that connection, or cause

and effect has been clearly made at this point. But, if it does result in such, then the way I see it, the beneficiaries of such competition will be limited to young people with no negative health status, working in what is considered a low liability industry, in an area of the state that is not deemed to be more expensive than others. Based on the demographics of our state, that doesn't cover too many people. For the rest of us, we will face continuing increased costs which will eventually be crippling. Small employers will have to reconsider the plans they offer employees, offering plans with reduced benefits and higher deductibles and premiums, thus increasing their employees' out of pocket costs, or worse yet, they may not be able to afford any health coverage at all.

Which brings me back to the point I made earlier – I believe this legislation actually goes against the goal of providing affordable, comprehensive health coverage for every citizen. It certainly works against me and I believe I represent a very large number of New Hampshire citizens.

The disturbing affects that this legislation will have on me and others like me, don't stop at increased premiums and the struggle to provide health coverage as a result. They go well beyond that. What if I close my business and seek employment elsewhere? This legislation will require me to complete an extensive questionnaire on mine and my family's health status. Small employers may be hesitant to hire individuals without the most favorable health status for fear of the increased costs of premiums. The information and knowledge about the people's health risks, which hasn't been collected for years will now be of concern to employers and the state.

The potential for discrimination is immeasurable. My professional development and future may be harmed by such disclosure. And how is it that as an employee I could be required to disclose my health status to my employer, who will then disclose it to its insurance company but per the new HIPPA regulations I can't even be publicly referred to as a patient in a medical facility? These principles are in direct conflict with one another. I will be at risk, others who have not had a perfect medical history will be at risk.

Thus, this legislation not only discriminates against small businesses but it most certainly discriminates against cancer patients like myself and other people with significant illnesses. I had always thought that the purpose of health insurance, like other types of insurance, was to pool risks among large numbers of people so that everyone would benefit from lower premiums. In the case of health insurance, in a very real sense the premiums of healthy people – whose claims are less than their premiums – helps pay for the health care of sick people whose claims are greater than their premiums. This legislation changes all of that. Now, sick people and the small businesses unlucky enough to employ them will be paying more for their health insurance. The risk is being transferred from the insurer to the insured, and in the process, we are really throwing out the window traditional notions of how insurance is supposed to work. Why? Apparently because some members of the legislature believe that some insurers who are not now willing to do business in New Hampshire will now agree to do so if we can assure them that we are willing to discriminate against sick people and small businesses on their behalf.

I realize the need for competition in the market in order to drive competitive pricing. I just think there might be other ways to achieve that – ways that will not punish or discriminate against a large portion of New Hampshire citizens; ways that will be more equitable in their attempts to provide what should be a right of everyone – affordable, comprehensive health coverage.

I am asking you today to consider the very real impact that this legislation will have on me and others like me and after you do, that you recommend this bill for defeat, or at the very least recommend it for further study.

Thank you for your time and consideration.

Pool
Administrators
Inc.
PAI

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Testimony by Karl Ideman, Administrator for the Connecticut Small Employer Health Reinsurance Pool

Good afternoon, my name is Karl Ideman and I am providing testimony as the Administrator of nearly thirty high risk and reinsurance pools and as a past Board member of five others. I would like to provide some background on the reinsurance pools and then to share my observations on the deterioration of the individual and small employer markets. Finally, I will talk about our Connecticut experience which demonstrates the positive role a reinsurance pool can play to improve the marketplace problems.

Since not everyone is deeply involved in pooling and insurance reform, I would like to start with some background. First, our company is called Pool Administrators Inc. and we are in the business of design and implementation as well as administration of state mechanisms to facilitate access in the individual and small employer markets. It is the only thing we do.

The Pooling Concept is Quite Simple

> If you spread enough risk and cost
> Then all carriers accept all risks
> By equitably sharing net losses
> So there is no insurance risk selection

If risk spreading is not adequate then there is more insurance risk selection
As there are fewer carriers there is more risk assumption and there is even more undesirable Risk Selection or undesirable risk avoidance. There are more carriers exiting the market or going to the sidelines to nurture their existing block of business in lieu of actively marketing. There is more "field underwriting", more improper "boundary management" and more attempts to get "carve outs". These improper market behaviors may become legitimized by more risk-based pricing and more "safe harbors" where the health plan doesn't have to guarantee issue.

In order to create a market climate that provides an incentive for carriers to actively market, the approach we endorse is to pool risks that have or are expected to have the highest costs and to spread their actual costs back equitably over a large base to reduce their impact on the carrier that normally would have to shoulder the risk in its entirety. This approach can be used in various ways in both the small employer and in the individual markets to reduce claim fluctuations and to spread risk. The reinsurance processes these programs use is a standardized and cost-effective process that has been well received by the carriers that participate. The structure for the programs comes from the original design and implementation from the Connecticut program and then the NAIC Reinsurance Model Act.

These programs are self-funded by the member carriers and each carrier can choose how much it wants to use the facility for the business it has sold. Carriers that actively market can make the best use of the facility because all reinsurance programs allow carriers to

cede new groups within 60 days of their effective dates. All but one program allows carriers to select high cost new enrollees and, the most successful program, Connecticut goes as far as to allow ceding on the third renewal of the group. In this way the programs can be instrumental in facilitating the sale and retention of small employer and individual health insurance.

All programs offer guaranteed renewable reinsurance with reinsurance premium rates that are limited by law. This self-funded reinsurance should be cheaper and it should not be redundant with private reinsurance. It should improve the carrier's control of and predictability of insurance rates. The Programs have standard plans of reinsurance that are comprehensive and have been tailored to indemnity, PPO and HMO business. Premium adjustments are offered to HMOs and a local line of credit protects cash flow.

An independent CPA firm assures fair and accurate financial results through an annual audit. Assessments of program losses are usually apportioned to carriers based on their respective market share of small employer health insurance written in the state. Although the programs are designed to spread risk by assessment of losses, the largest assessment impact on a carrier's business in any state has only been in the 1% range. Also, these assessments are not necessarily an added cost to the small employers or the marketplace but merely a spreading or shift in the cost amongst the carriers. The largest cost shift allowable is 5% and no one has come close to this limit.

The only incremental cost for the programs is administration expense, and these costs are low because the administration also is standardized and it is automated to reduce cost and ease effort. The actual reinsurance process is simple and is described in detail in an Operations and Procedures Manual that is presented to each carrier. This automation includes a reinsurance reporting system available to all participating carriers. **In Connecticut, investment income has paid for more than 95% of total administrative expenses so there is virtually no incremental cost to the carriers.**

Overview of the Reinsurance Process

Membership in the program is determined (mandatory or voluntary).
Agents/brokers and carriers write new (or in one state, renewal) business.
Member carriers select risks for ceding based on expected claims.
Carriers notify the program of their intent to cede.
Carriers calculate and remit reinsurance premium.
The program accepts all eligible risks.
The program guarantees automatically renewable reinsurance coverage.
Carriers adjudicate and submit claims for reimbursement.
The Program reimburses carrier claims.
The Program estimates loss reserves, calculates losses and produces audited financials.
The Board of Directors of the Program decides whether an assessment is needed.
The cycle continues from year to year.

To summarize this background information I would like to take you back to the simple concept that adequate risk spreading makes carriers more willing to accept new risk and not to engage in undesirable market practices to avoid risk. In other words, reinsurance pools present themselves as good public policy with significant overall cost/benefit implications. It is good public policy to treat everyone equally. From a public policy standpoint, high cost groups with poor health history are treated the same by the carriers as their healthy counterparts are treated because the reinsurance takes place in the background and is transparent to the employees and their dependents.

In the Reinsurance Model, the employer can shop for the best coverage from all of the Health Insurers and can pick the coverage that fits his/her pocketbook. The Insurer can then cede selected high risk individuals to the Pool. The reinsurance coverage and claims reimbursement arrangement is "transparent" to the reinsured person. Also, there are no rejections for health conditions and coverage is guaranteed renewable. By its design, this pooling approach is the most efficient for the consumer.

The cost/benefit premise is built on the assumption that the highest costs are concentrated amongst a few risks whose excess costs can be managed and spread equitably to all carriers and all risks so that the additional cost per risk will be small. These have proven to be valid premises. Most notable is the result of the cost spreading:

> **The average assessment has been a fraction of one percent of the member carrier's earned premium.**

Connecticut pioneered the state pooling initiatives starting with the nation's first individual high risk pool in 1976 and the first small employer reinsurance pool in 1990. Both of these pools became prototypes for NAIC Model Laws and pools of both types in thirty states. I will focus on the small employer market and the reinsurance pool.

THE CONNECTICUT EXPERIENCE

The problems in the marketplace when we began our work in Connecticut in 1989 is that there were unreasonable rates and rate increases with the most pain felt by employer groups of less than ten employees. Carriers and agents were engaging in risk avoidance or they were splitting groups to only take the good risks. There were employer inequities and there was some steering of business to certain carriers. To compound the negative developments there were the emerging MEWAs and the reduction of insurer capacity by the movement of employers to self-funding or partial self-funding.

Additional incentive for change came from the national reform movement by Public Sector. Guarantee issue and rate reform was being introduced in the states and National Health Insurance was presented by the Clintons. The Private Sector had to take the initiative so there was significant collaboration amongst traditional rivals and Board members took off their company hats for the good of the industry and the market. The

overriding belief was that the private sector was most efficient and most objective way to implement reform.

Connecticut had the ingredients for a successful initiative. We had a core group of carriers with ample talent willing to spend time and money. The carriers trusted the Commissioner and the Commissioner had the confidence of the employer community.

This collaborative effort produced a model that was based on the first high risk pool where all licensed insurers are members. Members cast a weighted vote to elect board members and there is an Annual meeting of all members. We established a process for equitable assessment of losses, a line of credit to help manage cash flow between assessments, and an annual financial audit by independent CPA firm to assure adequate support for assessments.

The resulting prototype design became the The Connecticut Small Employer Health Reinsurance pool (CSEHRP). The key features of CSEHRP became the national model and are the same as I described previously. Reinsurance is transparent to the employer and the employees. New business can be ceded within 60 days of coverage effective date Carriers have no coinsurance after the deductible so they are more risk neutral because they know their exposure is limited to $5,000 plus the reinsurance premium. These are manageable amounts that can be planned and controlled by the carrier.

CSEHRP carefully balanced reinsurance rates vs. carrier benefits. It also eased the transition to modified community rating by allowing ceding from the existing book of business. A key principle that has not been followed in all pools is that the reinsurance premium cannot be passed on to specific groups. Most notable in the success of CSEHRP has been a Board committed to a fair and efficient market. The board developed the NAIC prototype for the Fair Marketing Guidelines and pioneered the initial approach to rate regulation through bands. Case characteristics were limited to demographics and there was no rate up allowed for health, SIC code geography, tobacco use, etc. We had active participation and support from the agents and brokers who we utilized to launch an extensive program to facilitate marketing and communication. We did market research of buying habits and developed a prototype comprehensive plan and a low income plan, both of which exist today.

There were favorable results in the Marketplace. There was rate stabilization and single digit increases. Carriers entered the market and there was an ample supply of all product types. There was self-policing of potential market abuses and there were positive market research results from small employers

CSEHRP's results were also impressive. It responded to the emergence of HMOs by introducing a Reinsurance deductible at $ 5,000 to accommodate federally qualified HMOs. CSEHRP had lower than expected loss ratios for 7 years (now at expected). Ceding on renewal continued as an incentive against rate-up. We found that Carriers less effective in ceding and claims reimbursement than we expected with the result that

assessed losses were less than 1% of premium base. Thirty-seven (37) carriers have actively ceded lives and there have been more than 27,000 lives in the pool over the years. Despite all of the exits and consolidation of carriers nationally, I am proud to say that we still have more than twenty carriers with filed small employer plans in Connecticut. What we have learned is that Pool helped most carriers and hurt none, that the market responds to centralized market initiatives and that the Pool facilitates efficient supply and may increase demand of the insurance product.

In closing, I would like to state that there are no disadvantages to the consumer and to the market if New Hampshire has both a high risk and a reinsurance pool in the state like we do here in Connecticut. Personally, as stated above, I think that the two can exist side by side, or better yet, they can be integrated to achieve market synergies that are not available separately. The high risk pools that issue coverage directly (insurance) have to be carefully managed to assure that they don't cannibalize the voluntary market and they don't generate losses that can't be absorbed by those being assessed or otherwise subsidizing the pool. The reinsurance pools also have to be carefully designed to assure that the process is equitable to the carriers and supportive of fair marketing practices.

Thank you for the opportunity to speak to you today.

Health Reinsurance Programs
Simple, Safe and Effective Mechanisms

These programs have been implemented to reduce claim fluctuations and to spread risk in the small employer and individual insurance markets. The reinsurance processes these programs use is a standardized and cost-effective process that has been well received by the carriers that participate. The structure for the programs comes from the original design and implementation from the Connecticut program and then the NAIC reinsurance model act.

These programs are self-funded by the member carriers and in any case, each carrier can choose how much it wants to use the facility for the business it has sold. Carriers that actively market can make the best use of the facility because all reinsurance programs allow carriers to cede new groups within 60 days of their effective dates. All but one program allows carriers to select high cost new adds and the most successful program goes as far as to allow ceding on the third renewal of the group. In this way the programs can be instrumental in facilitating the sale and retention of small employer and individual health insurance.

All of the programs offer guaranteed renewable reinsurance with reinsurance premium rates that are limited by law. This self-funded reinsurance should be cheaper and it should not be redundant with private reinsurance. It should improve the carrier's control of and predictability of insurance rates. The Programs have standard plans of reinsurance that are comprehensive and have been tailored to indemnity, PPO and HMO business. Premium adjustments are offered to HMOs and a local line of credit protects cash flow.

An independent CPA firm assures fair and accurate financial results through an annual audit. Assessments of program losses are usually apportioned to carriers based on their respective market share of small employer health insurance written in the state. Although the programs are designed to spread risk by assessment of losses, the largest assessment impact on a carrier's business in any state has only been in the 1% range. Also, these assessments are not necessarily an added cost to the small employers or the marketplace but merely a spreading or shift in the cost amongst the carriers. The largest cost shift allowable is 5% and no one has come close to this limit.

The only incremental cost for the programs is administration expense, and these costs are low because the administration also is standardized and it is automated to reduce cost and ease effort. The actual reinsurance process is simple and is described in detail in an Operations and Procedures Manual that is presented to each carrier. This automation includes a reinsurance reporting system available to all participating carriers.

Overview of the Reinsurance Process

1. Membership in the program is determined (mandatory or voluntary).
2. Agents/brokers and carriers write new (or in one state, renew) business.
3. Member carriers select risks for ceding based on expected claims.
4. Carriers notify the program of their intent to cede.
5. Carriers calculate and remit reinsurance premium.
6. The program accepts all eligible risks.
7. The program guarantees automatically renewable reinsurance coverage.
8. Carriers adjudicate and submit claims for reimbursement.
9. The Program reimburses carrier claims.
10. The Program estimates loss reserves, calculates losses and produces audited financials.
11. The Board of Directors of the Program decides whether an assessment is needed. The cycle continues from year to year.

From DOI (12/02)

STATE BY STATE SMALL EMPLOYER STATE INSURANCE RATING REFORMS, 1997

State	Composite Band	Health	Industry	Age	Geography	Gender	Group Size	Family Composition
Alabama	N/A	No restrictions	PROHIBITED	*4:1*	No restrictions	No restrictions	PROHIBITED	No restrictions
Alaska	N/A	*2.08:1*	*1.35:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Arizona	*4:1*	Included in composite band	No restrictions	No restrictions	Included in composite band	No restrictions	No restrictions	Included in composite band
Arkansas	N/A	*2:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
California	N/A	*1.22:1*	PROHIBITED	No restrictions	No restrictions	PROHIBITED	PROHIBITED	No restrictions
Colorado	*1.22:1*	Included in composite band	Included in composite band	No restrictions	No restrictions	PROHIBITED	PROHIBITED	No restrictions
Connecticut	N/A	PROHIBITED	*1.35:1*	No restrictions	No restrictions	No restrictions	*1.25:1*	No restrictions
Delaware	*1.22:1*	*Restricted independently by 2.5:1*	*Restricted independently by 1.15:1*	No restrictions	Included in composite band	Included in composite band	No restrictions	No restrictions
Washington, DC	N/A	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Florida	N/A	PROHIBITED	PROHIBITED	No restrictions	No restrictions	No restrictions	PROHIBITED	No restrictions
Georgia	N/A	*1.67:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Hawaii	N/A		No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Idaho	*2:1*	Included in composite band	Included in composite band	No restrictions	Included in composite band	No restrictions	Included in composite band	No restrictions
Illinois	N/A	*2:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Indiana	N/A	*2.08:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Iowa	N/A	*2:1*	PROHIBITED	No restrictions	No restrictions	PROHIBITED	No restrictions	No restrictions
Kansas	N/A	*2:1*	*1.3:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions

05/15/01
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STATE BY STATE SMALL EMPLOYER STATE INSURANCE RATING REFORMS, 1997

State	Composite Band	Health	Industry	Age	Geography	Gender	Group Size	Family Composition
Kentucky	*5:1*	PROHIBITED	*Restricted in composite band by 1.15:1*	*Restricted in composite band by 3:1*	Included in composite band	Included in composite band	PROHIBITED	No restrictions
Louisiana	N/A	*2:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Maine	*1.5:1*	PROHIBITED	Included in composite band	Included in composite band	Included in composite band	PROHIBITED	No restrictions	No restrictions
Maryland	*1.99:1*	PROHIBITED	PROHIBITED	Included in composite band	Included in composite band	PROHIBITED	PROHIBITED	No restrictions
Massachusetts	*2:1*	PROHIBITED	Included in composite band	Included in composite band	No restrictions	PROHIBITED	Included in composite band	Included in composite band
Michigan	N/A		No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Minnesota	*1.67:1*	Included in composite band	Included in composite band	*Restricted independently by 3:1*	*Restricted independently by 1.2:1*	PROHIBITED	PROHIBITED	No restrictions
Mississippi	N/A	*2:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Missouri	N/A	*2:1*	*1.22:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Montana	N/A	*2:1*	*1.35:1*	No restrictions	No restrictions	PROHIBITED	*1.2:1*	No restrictions
Nebraska	N/A	*2:1*	*1.15:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Nevada	N/A	*1.86:1*	*1.2:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
New Hampshire	N/A	PROHIBITED	PROHIBITED	*3:1*	PROHIBITED	PROHIBITED	No restrictions	No restrictions
New Jersey	*2:1*	PROHIBITED	PROHIBITED	Included in composite band	Included in composite band	Included in composite band	PROHIBITED	No restrictions
New Mexico	*2.5:1*	*Restricted independently by 1.8:1*	PROHIBITED	Included in composite band	Included in composite band	*Restricted in composite band by 1.2:1*	PROHIBITED	No restrictions
New York	N/A	PROHIBITED	PROHIBITED	PROHIBITED	No restrictions	PROHIBITED	PROHIBITED	No restrictions

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STATE BY STATE SMALL EMPLOYER STATE INSURANCE RATING REFORMS, 1997

State	Composite Band	Health	Industry	Age	Geography	Gender	Group Size	Family Composition
North Carolina	N/A	*1.5:1*	PROHIBITED	No restrictions	No restrictions	No restrictions	PROHIBITED	No restrictions
North Dakota	N/A	*1.73:1*	*1.15:1*	No restrictions	No restrictions	PROHIBITED	*1.2:1*	No restrictions
Ohio	N/A	*2.08:1*	*1.35:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Oklahoma	N/A	*2:1*	*1.15:1*	No restrictions	No restrictions	No restrictions	*1.2:1*	No restrictions
Oregon	N/A	PROHIBITED	PROHIBITED	*3:1*	PROHIBITED	PROHIBITED	PROHIBITED	No restrictions
Pennsylvania	N/A		No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Rhode Island	N/A	*2:1*	*1.3:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
South Carolina	N/A	*1.22*	No restrictions	No restrictions	No restrictions	No restrictions	PROHIBITED	No restrictions
South Dakota	N/A	*2:1*	*1.15:1*	*3:1*	No restrictions	No restrictions	No restrictions	No restrictions
Tennessee	N/A	*2.6:1*	*1.35:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Texas	N/A	*2:1*	*1.15:1*	No restrictions	No restrictions	No restrictions	*1.2:1*	No restrictions
Utah	N/A	*2.2:1*	*1.15:1*	No restrictions	No restrictions	No restrictions	*1.2:1*	No restrictions
Vermont	*1.5:1*	PROHIBITED	Included in composite band	Included in composite band	PROHIBITED	Included in composite band	PROHIBITED	No restrictions
Virginia	N/A	*1.5:1*	PROHIBITED	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Washington	*4:1*	PROHIBITED	PROHIBITED	Included in composite band	Included in composite band	PROHIBITED	PROHIBITED	Included in composite band
West Virginia	N/A	*2.2:1*	*1.15:1*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Wisconsin	N/A	*1.86*	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions	No restrictions
Wyoming	N/A	*2:1*	*1.35:1*	No restrictions	No restrictions	No restrictions	*1.2:1*	No restrictions

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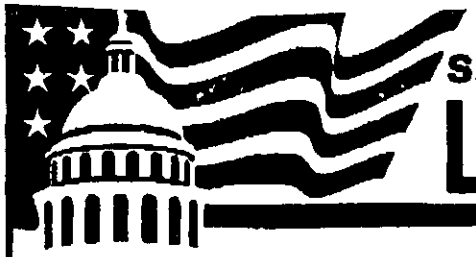
SMALL EMPLOYER STATE INSURANCE RATING REFORMS, Dec 1997 – Feb 2000
IN STATES PROHIBITING HEALTH RATING

State	1997 Status of Rating Reforms									Jan 2000
	ER Size	Composite Band	Health	Industry	Age	Geography	Gender	Group Size	Family Comp	CHANGES
Kentucky*	2-50	5:1	No	Restricted in composite band by 1.15:1	Restricted in composite band by 3:1	Included in composite band	Included in composite band	No	Allowed	Allow the use of HEALTH status. Effective July 1998. Applies to all who are in the plans that fall under the insurance reform. There are separate rating bands for individual.
Vermont*	1-50	1.5:1	No	Included in composite band	Included in composite band	No	Included in composite band	No	Allowed	Shift to flat community rating. Effective January 2000 for new enrollees. Phase-down for existing enrollees. ± 15 during 2000.
Connecticut	1-50	N/A	No	1.35:1	Allowed	Allowed	Allowed	1.25:1	Allowed	When a self-employed individual opts to apply for an individual health insurance plan, the carrier is required to disclose on the application and marketing materials that the plan is issued on an individual basis and is regulated as an individual health insurance plan. Effective 1998.
Florida	1-50	N/A	No	No	Allowed	Allowed	Allowed	No	Allowed	2000 legislation allows health rating for groups & modifies treatment of groups size of one in that they can only enroll during the month of August.
Maine*	1-50	1.5:1	No	Included in composite band	Included in composite band	Included in composite band	No	Allowed	Allowed	No changes since 1997.
Maryland	1-50	1.99:1	No	No	Included in composite band	Included in composite band	No	No	Allowed	No changes since 1997.
Massachusetts	1-50	2:1	No	Included in composite band	Included in composite band	Allowed	No	Included in composite band	Allowed	Previously legislated tightening of rating band to 1.5:1, to be effective 12/31/99, was repealed.
New Hampshire	1-100	N/A	No	No	3:1	No	No	Allowed	Allowed	No changes since 1997.
New Jersey	2-50	2:1	No	No	Included in composite band	Included in composite band	Included in composite band	No	Allowed	No changes since 1997.
New York*	2-50	N/A	No	No	No	Allowed	No	No	Allowed	No changes since 1997.
Oregon*	2-26**	N/A	No	No	2:1	Allowed	No	No	Allowed	Tightened age rating band from 3:1 to 2:1 as regulated by statute in 1999.
Washington*	1-50	N/A	No	No	4.1	Allowed (not generally used)	No	No	Included in composite band	Age band reduced to 3.75:1. Effective January 1, 2000.
Colorado	2-50	1.22:1	Included in composite band	Included in composite band	Allowed	Allowed	No	No	Allowed	1) Eliminated composite band, prohibit health & industry rating, effective 1998. 2) Effective 2000, health underwriting allowed for groups of 1 unless they enroll on birthday month.

* Allows some rating differential for qualifying association plans.
** Small groups of 2-50 for guarantee renewal in compliance with HIPAA.

No = Prohibited Allowed = No restrictions

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SMALL BUSINESS SERVICE BUREAU, INC.

LEGISLATIVE ALERT

The Voice of American Small Business

N.H. Legislature Plans Big Health Care Premium Hikes for 80% of Businesses in the State

Self Employed and Other Small Employers Will Be Hit Especially Hard

The New Hampshire Legislature plans big health care premium hikes for the self employed and other small employers, about 80 percent of all employers in the state. Sole proprietors and small employers with fewer than 50 employees will be subjected to new rating rules and the self employed also will be hit with rate differentials that will significantly hike premiums.

The bill, S.B. 110, would force sole proprietors to pay up to 30 percent more in premiums than other small groups, based on rate differentials. It also would unfairly require sole proprietors and other small groups to complete extensive medical health questionnaires to determine your "health experience rating." As a result, if you, your employees or dependents have high blood pressure, heart disease or diabetes, your premiums will jump up dramatically.

Additionally, S.B. 110 allows small groups to be penalized based on their industry. Businesses ranging from health care and social service to construction, auto repair, lodging and transportation can be deemed "high risk," resulting in even higher rate hikes. And businesses with older employees will also be forced to pay more.

S.B. 110, which recently was heard in the House Commerce Committee and will be debated in the House shortly, is unfair and bad for small business. Small Business Service Bureau, Inc. (SBSB) fears the bill will drive thousands of sole proprietors and other companies into the ranks of the uninsured. It also means small groups will be required to collect confidential health information on employees just to get insurance –increasing paperwork and compliance costs due to medical privacy regulations.

While big businesses are allowed to negotiate deep discounts on health care premiums, small employers are being forced out of the small group market and subjected to additional government regulations–and that's wrong.

S.B. 110 may be good for big business, but it hurts the state's smallest businesses, which are vital to New Hampshire's economy. ***Call (603) 271-2548 and ask to speak to your State Representative today! To contact your Senator call (603) 271-3420. Tell them S.B. 110 unfairly penalizes the self employed and is bad for all small businesses.***

Need More Information, or Help Contacting Your Elected Officials?

Call SBSB Advocates Legislative Coalition Toll Free at 1-800-343-0939, extension 234.

Subcommittee Amendment to SB 110 – DRAFT **as of 5/6/03**

This document contains the entire text of SB 110 as amended by the Senate. All amendments discussed by the Commerce subcommittee are indicated by highlighting. These changes have not necessarily been adopted by the subcommittee.

1 Definition; "~~Community~~ *Base* Rate." RSA 420-G:2, I is repealed and reenacted to read as follows:

I. "~~Community~~ *Base* rate" means a single rate reflecting the carrier's average cost of actual or anticipated claims for all health coverages or health benefit plans the carrier writes and maintains in a market, including the nongroup individual health insurance market and the small employer group health insurance market.

2 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph IX the following new paragraph:

IX-a. "Health coverage ~~base~~ *plan* rate" means a rate that is uniquely determined for each of the coverages or health benefit plans a health carrier writes and that is derived from the ~~community~~ *base* rate through the application of factors that reflect actuarially demonstrated differences in expected utilization or cost attributable to differences in the coverage design and/or the provider contracts that support the coverage.

3 Definition of Large Employer. Amend RSA 420-G:2, XII(a) to read as follows:

XII.(a) "Large employer" means an employer that employed on average at least [~~101~~] *51* persons, on business days, during the previous calendar year.

4 Definition of a Small Employer. Amend RSA 420-G:2, XVI(a) to read as follows:

XVI.(a) "Small employer" means a business or organization which employed on average, one and up to [~~100~~] *50* employees, including owners and self-employed persons, on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

5 Premium Rates for Small Employers. RSA 420-G:4, I is repealed and reenacted to read as follows:

I. Health carriers providing health coverage to individuals and small employers under this chapter shall be subject to the following:

(a) All premiums charged shall be guaranteed for ~~at least 6 months~~ *the term of the contract* (adopt?)

(b) Community rate shall be established by each health carrier for all of its health coverages offered to individuals and, ~~separately,~~ *a base rate shall be established* for all of its health coverages offered to small employers.

(c) Health carriers shall calculate health coverage ~~base~~*plan* rates for each of the coverages or health benefit plans written by that carrier. Variations in health coverage ~~base~~*plan* shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

(d) In establishing the premium charged, health carriers providing coverage to individuals shall calculate a rate that is derived from the health coverage ~~base~~*plan* rate through the application of rating factors that the carrier chooses to utilize for age, health status, and tobacco use. Such factors may be utilized only in accordance with the following limitations:

(1) The maximum premium differential for age as determined by ratio shall be 4 to 1. The limitation shall not apply for determining rates for an attained age of less than 19.

(2) The maximum differential due to health status shall be 1.5 to 1 and the maximum differential rate due to tobacco use shall be 1.5 to 1. Rate limitations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(3) Permissible rating characteristics shall not include changes in health status after issue.

(e) In establishing the premium charged, health carriers providing coverage to small employers shall calculate a rate that is derived from the health coverage ~~base~~*plan* rate through the application of rating factors that the carrier chooses to utilize for age, group size, industry classification, geographic location, ~~and~~ health status *and tobacco use*. *Costs related to any rating factor shall be applied only once* (review). Such factors may be utilized only in accordance with the following limitations:

(1) Carriers may use the attained age of covered persons as a rating factor. However, the maximum premium differential for age as determined by ratio shall be 4 to 1 beginning with age 19.

(2) Carriers modifying such average premium for age may do so only by using the following age brackets:

0 - 18
19 - 24
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 +

(3) Carriers may use group size as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more

than 20 percent; provided that for groups of one, an additional 10 percent rating factor shall be allowed from the highest factor.

(4) Carriers may use the small employer group's industry classification as a rating factor. However, the highest factor based on industry classification shall not exceed the lowest factor based on industry classification by more than 20 percent.

(5) Carriers may use the small employer group's geographic location as a rating factor. However, the highest factor based on geographic location shall not exceed the lowest factor based on geographic location by more than 15 percent.

(6) Carriers may use the health status of the small employer group as a rating factor. However, the application of a health status factor shall be subject to the following limitations:

(A) The health status factor may reflect health status of covered persons, the small employer's claim experience, or the duration of coverage since health statements were last provided.

(B) Variations from the arithmetic average of the highest rate charged to the lowest rate charged shall not exceed 25 percent.

(C) Upon the renewal of a small employer policy, any increase in the premium rate that is solely attributable to changes in the health status factor from the prior year shall be no more than 15 percent.

(7) *Carriers may use the tobacco use of members of the small employer group as a rating factor. However, the highest factor based on tobacco use for any individual in the group shall not exceed the lowest factor for members who are not tobacco users by more than 50 percent.* (need to review)

(8) Upon the renewal of a small employer policy, a carrier is prohibited from increasing the premium rate by more than 25 percent of the rate that was charged in the preceding year. Such rate increase limitation shall not include any premium rate increase that is based on a carrier's annual cost and utilization trends or changes in the rating factor for attained age of covered persons. This subparagraph shall expire on January 1, 2005.

(f) The same rating methodology shall apply to newly covered individuals and to individuals renewing at each annual renewal date, or to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

(g) The commissioner shall not approve any filing if such filing is excessive, inadequate or contrary to the intent of this chapter.

6 Medical Underwriting. RSA 420-G:5 is repealed and reenacted to read as follows:

420-G:5 Medical Underwriting.

I Health carriers providing health coverage for individuals or small employer groups may perform medical underwriting, including the use of health statements or screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4. Such underwriting may be limited to the use of a

This Document did not include a Page 4

New section (HB 596 as adopted by the House):

Group Health Insurance; Health Plan Loss Information. RSA 420-G:12-a is repealed and reenacted to read as follows:

420-G:12-a Health Plan Loss Information.
I. To ensure maximum competition in the purchase of group health insurance, all private and public employers with at least 50 employees enrolled in their group health plan shall be entitled to receive their specific health plan loss information upon request and without charge. No contract between any health carrier, third-party administrator, employer group or pool of employers shall abridge this right in any manner.
II. Upon written request from any private or public employer with 50 or more employees enrolled in its group health plan, every health carrier, third-party administrator, pooled risk management program under RSA 5-B or any other type of multiple employer health plan shall provide that employer's loss information within 30 calendar days of receipt of the request. The loss information shall include all physician, hospital, prescription drug, and other covered medical claims specific to the employer's group plan incurred for the 12-month period paid through the 14 months which end within the 60-day period prior to the date of the request. An employer shall not be entitled by this section to more than 2 loss information requests in any 12-month period; however, nothing shall prohibit a carrier from fulfilling more frequent requests on a mutually agreed-upon basis.
III. If an employer requests loss information from an insurance agent or other authorized representative, including an administrator of a pooled risk management program or a multiple employer health plan, the agent or authorized representative shall transmit the request to the health carrier or carriers or third-party administrator within 4 working days.

8 Repeal. RSA 420-G:8, I(b), relative to medical underwriting, is repealed.

9 Effective Date. This act shall take effect ~~July 1, 2003~~ ***January 1, 2004***.

Voting Sheets

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on SB 110

BILL TITLE: **relative to small group health insurance coverage.**

DATE: May 20, 2003

LOB ROOM: 302

Amendments:

Sponsor: Rep. Hunt — OLS Document #: 2003 1713h

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

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

Moved by Rep. Fraser Amendment

Seconded by Rep. Flanders

Vote: 17-0 (Please attach record of roll call vote.)

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

Moved by Rep. Fraser

Seconded by Rep. Flanders

Vote: 10-8 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: Regular

(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 #: SB-110 Title:

PH Date: / / Exec Session Date: 5 / 20 / 03

Motion: OTP Amendment #: 1713h

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	0

TOTAL VOTE:

Printed: 1/6/2003

OFFICE OF THE HOUSE CLERK

2003 SESSION

COMMERCE

Bill #: SB-110 **Title:**

PH Date: ___/___/___ **Exec Session Date:** 5/20/03

Motion: OTP/A **Amendment #:**

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		✓
	9 10	8

TOTAL VOTE:

Printed: 1/6/2003

Committee Report

MAJORITY
COMMITTEE REPORT

COMMITTEE: **Commerce**

BILL NUMBER: **SB 110**

TITLE: relative to small group health insurance coverage.

DATE: May 20, 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 bill has been in the making for several years. Similar legislation was introduced two sessions ago, but the Commerce committee felt at that time that the changes to the individual market needed to happen first. The reforms in this legislation are designed to bring more insurance companies and products back into the state and to make the small group health insurance market more competitive. The committee held many work sessions on this bill to insure that each element of the bill was understood and made sense for New Hampshire. Currently New Hampshire is a "community rated" state with only age and group size as allowable rating factors. What this means is that the premium paid in New Hampshire for a particular health benefit plan from a particular insurer will not differ by very much from one small employer to another. As predicted when this law was debated almost 10 years ago, the current law disfavored insurance companies offering indemnity type coverage, and many of them subsequently left the state. The vast majority of small employers now buy their coverage from a handful of HMOs. When the current law was passed, it was said to be model legislation that other states would adopt. About 12 states did pass community rating, but most states opted for a less restrictive scheme of rating parameters. This legislation will reintroduce competition by bringing back insurance underwriting. The bill changes the age banding from 3 to 1 to 4 to 1, which will match what we did in the individual market. It changes the definition of the small group market from the current 1 to 100 employees to 1 to 50. For employers who have 51 to 100 employees and now will be treated as large employers, the amendment limits the extent to which insurers can underwrite the group based on that group's own experience. New Hampshire was the only state that went to 100 for its definition of small employers. Every other state stops at 50 employees. This legislation also permits the use of new rating factors for industry classification, health status, and geographic location. There is a specified range that limits the extent to which each factor can be used, and in every case these ranges are similar to or more stringent than what most other states allow. The one factor that seemed to generate the most controversy was geographic location. Ironically, this is the one of the factors that is permitted without limitation by the vast majority of the other states. The Insurance Department reported that they believe that the north

country and the sea coast could be the areas most affected by the introduction of increased rating flexibility due to the higher medical loss ratios reported by insurers writing in those regions. However, the Department believes that this impact is not solely attributable to geographic rating. Although the legislation has caps on how much any one group's premium can go up, the Commerce committee is confident that the reintroduction of competition and more product choice will tend to limit the extend to which higher risk groups experience premium increases, making the caps largely unnecessary. Other insurance such as auto and life have very few limits or restrictions on rating factors, and New Hampshire has a very competitive and reasonably priced market for those types of insurance. The assumption that someone will be rated to the maximum of each factor is not how insurance underwriting works. Not all companies use all the factors, and not all companies that use a factor do so to the maximum extent allowable. Rating factors are just underwriting tools, and insurance companies often adjust a customer down to get their business. To say certain areas or people will be severely disadvantaged by allowing the use of rating factors is to disregard how insurance underwriting works and what is happening in other states. The Commerce committee also amended this bill to add new reporting requirements concerning the use of rating factors by insurers and creating an oversight committee to report annually on the impact of this legislation. This bill strikes a good balance between current law and the laws that exist in the many states that allow even greater underwriting flexibility in the small group market.

Vote 10-8.

Rep. John B. Hunt

FOR THE MAJORITY

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Commerce

SB 110, relative to small group health insurance coverage. OUGHT TO PASS WITH AMENDMENT Rep. John B. Hunt for Commerce: This bill has been in the making for several years. Similar legislation was introduced two sessions ago, but the Commerce committee felt at that time that the changes to the individual market needed to happen first. The reforms in this legislation are designed to bring more insurance companies and products back into the state and to make the small group health insurance market more competitive. The committee held many work sessions on this bill to insure that each element of the bill was understood and made sense for New Hampshire. Currently New Hampshire is a "community rated" state with only age and group size as allowable rating factors. What this means is that the premium paid in New Hampshire for a particular health benefit plan from a particular insurer will not differ by very much from one small employer to another. As predicted when this law was debated almost 10 years ago, the current law disfavored insurance companies offering indemnity type coverage, and many of them subsequently left the state. The vast majority of small employers now buy their coverage from a handful of HMOs. When the current law was passed, it was said to be model legislation that other states would adopt. About 12 states did pass community rating, but most states opted for a less restrictive scheme of rating parameters. This legislation will reintroduce competition by bringing back insurance underwriting. The bill changes the age banding from 3 to 1 to 4 to 1, which will match what we did in the individual market. It changes the definition of the small group market from the current 1 to 100 employees to 1 to 50. For employers who have 51 to 100 employees and now will be treated as large employers, the amendment limits the extent to which insurers can underwrite the group based on that group's own experience. New Hampshire was the only state that went to 100 for its definition of small employers. Every other state stops at 50 employees. This legislation also permits the use of new rating factors for industry classification, health status, and geographic location. There is a specified range that limits the extent to which each factor can be used, and in every case these ranges are similar to or more stringent than what most other states allow. The one factor that seemed to generate the most controversy was geographic location. Ironically, this is the one of the factors that is permitted without limitation by the vast majority of the other states. The Insurance Department reported that they believe that the north country and the sea coast could be the areas most affected by the introduction of increased rating flexibility due to the higher medical loss ratios reported by insurers writing in those regions. However, the Department believes that this impact is not solely attributable to geographic rating. Although the legislation has caps on how much any one group's premium can go up, the Commerce Committee is confident that the reintroduction of competition and more product choice will tend to limit the extend to which higher risk groups experience premium increases, making the caps largely unnecessary. Other insurance such as auto and life have very few limits or restrictions on rating factors, and New Hampshire has a very competitive and reasonably priced market for those types of insurance. The assumption that someone will be rated to the maximum of each factor is not how insurance underwriting works. Not all companies use all the factors, and not all companies that use a factor do so to the maximum extent allowable. Rating factors are just underwriting tools, and insurance companies often adjust a customer down to get their business. To say certain areas or people will be severely disadvantaged by allowing the use of rating factors is to disregard how insurance underwriting works and what is happening in other states. The Commerce Committee also amended this bill to add new reporting requirements concerning the use of rating factors by insurers and creating an oversight committee to report annually on the impact of this legislation. This bill strikes a good balance between current law and the laws that exist in the many states that allow even greater underwriting flexibility in the small group market **Vote 10-8.**

Stapler, Carol

From: John Hunt [jbhunt@prodigy.net]
Sent: Friday, May 23, 2003 6:07 PM
To: Carol Stapler
Subject: SB 110 Final

SB110 has been in the making for several years. Similar legislation was introduced two sessions ago, but the Commerce committee felt at that time that the changes to the individual market needed to happen first. The reforms in this legislation are designed to bring more insurance companies and products back into the state and to make the small group health insurance market more competitive. The committee held many work sessions on this bill to insure that each element of the bill was understood and made sense for New Hampshire. Currently New Hampshire is a "community rated" state with only age and group size as allowable rating factors. What this means is that the premium paid in New Hampshire for a particular health benefit plan from a particular insurer will not differ by very much from one small employer to another. As predicted when this law was debated almost 10 years ago, the current law disfavored insurance companies offering indemnity type coverage, and many of them subsequently left the state. The vast majority of small employers now buy their coverage from a handful of HMOs. When the current law was passed, it was said to be model legislation that other states would adopt. About 12 states did pass community rating, but most states opted for a less restrictive scheme of rating parameters.

This legislation will reintroduce competition by bringing back insurance underwriting. The bill changes the age banding from 3 to 1 to 4 to 1, which will match what we did in the individual market. It changes the definition of the small group market from the current 1 to 100 employees to 1 to 50. For employers who have 51 to 100 employees and now will be treated as large employers, the amendment limits the extent to which insurers can underwrite the group based on that group's own experience. New Hampshire was the only state that went to 100 for its definition of small employers. Every other state stops at 50 employees. This legislation also permits the use of new rating factors for industry classification, health status, and geographic location. There is a specified range that limits the extent to which each factor can be used, and in every case these ranges are similar to or more stringent than what most other states allow.

The one factor that seemed to generate the most controversy was geographic location. Ironically, this is the one of the factors that is permitted without limitation by the vast majority of the other states. The Insurance Department reported that they believe that the north country and the sea coast could be the areas most affected by the introduction of increased rating flexibility due to the higher medical loss ratios reported by insurers writing in those regions. However, the Department believes that this impact is not solely attributable to geographic rating. Unfortunately, the largest health insurance company in the state, the company with the most to loose if competition is reintroduced into the state used this issue to misrepresent this legislation In the north country where it is practically the sole health insurance provider

Although the legislation has caps on how much any one group's premium can go up, the Commerce committee is confident that the reintroduction of competition and more product choice will tend to limit the extend to which higher risk groups experience premium increases, making the caps largely unnecessary. Other insurance such as auto and life have very few limits or restrictions on rating factors, and New Hampshire has a very competitive and reasonably priced market for those types of insurance. The assumption that someone will be rated to the maximum of each factor is not how insurance underwriting works. Not all companies use all the factors, and not all companies that use a factor do so to the maximum extent allowable. Rating factors are just underwriting tools, and insurance companies often adjust a customer down to get their business. To say certain areas or people will be severely

disadvantaged by allowing the use of rating factors is to disregard how insurance underwriting works and what is happening in other states.

The Commerce committee also amended this bill to add new reporting requirements concerning the use of rating factors by insurers and creating an oversight committee to report annually on the impact of this legislation.

This bill strikes a good balance between current law and the laws that exist in the many states that allow even greater underwriting flexibility in the small group market.

MINORITY
COMMITTEE REPORT

COMMITTEE: **Commerce**

BILL NUMBER: **SB110**

TITLE: relative to small group health insurance coverage.

DATE: May 20, 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)

The minority approaches healthcare reform from the perspective that 91% of New Hampshire adults and children have healthcare. We are the healthiest state in the United States. Further, 76% of those insured receive their insurance from their employers who are in the small group market. Therefore, when altering the small group market any legislation should do so from the premise of not reducing the amount of insured. At the heart of the legislation is underwriting and the ability of insurers to manipulate the risk pool. In the case of SB 110 it will be easier for insurers to segregate the healthy from the unhealthy. The proponents of this bill say that these changes will create competition amongst insurers and therefore drive down premiums. Upon exhaustive hearings and a plethora of information provided to the committee, there was not evidence that there would be a decrease in premiums. The best that the proponents could say was that premiums would not go up as much and there would be new products introduced into the market. The minority felt that an unintended consequence could be an increase in uninsured. Further, the bill does not address the underlying costs that are driving healthcare-utilization and administration. Recognizing the importance of the legislation and the need to create appropriate competition, the minority felt that the bill should be retained and worked on in combination with two other bills retained by the committee, HB 265 and HB 652 which address the cost drivers of healthcare.

Vote {Type VOTE}.

Rep. Matthew J. Quandt
FOR THE MINORITY

Original: House Clerk
cc: Committee Bill file

Commerce

SB110, relative to small group health insurance coverage. **INEXPEDIENT TO LEGISLATE** Rep. Matthew J. Quandt for Commerce: The minority approaches healthcare reform from the perspective that 91% of New Hampshire adults and children have healthcare. We are the healthiest state in the United States. Further, 76% of those insured receive their insurance from their employers who are in the small group market. Therefore, when altering the small group market any legislation should do so from the premise of not reducing the amount of insured. At the heart of the legislation is underwriting and the ability of insurers to manipulate the risk pool. In the case of SB 110 it will be easier for insurers to segregate the healthy from the unhealthy. The proponents of this bill say that these changes will create competition amongst insurers and therefore drive down premiums. Upon exhaustive hearings and a plethora of information provided to the committee, there was not evidence that there would be a decrease in premiums. The best that the proponents could say was that premiums would not go up as much and there would be new products introduced into the market. The minority felt that an unintended consequence could be an increase in uninsured. Further, the bill does not address the underlying costs that are driving healthcare-utilization and administration. Recognizing the importance of the legislation and the need to create appropriate competition, the minority felt that the bill should be retained and worked on in combination with two other bills retained by the committee, HB 265 and HB 652 which address the cost drivers of healthcare {Type **VOTE**}.

Stapler, Carol

From: John Hunt [jbhunt@prodigy.net]
Sent: Friday, May 23, 2003 6:02 PM
To: Karen Wadsworth; Carol Stapler
Subject: FW: SB 110 Minority Report & SB110 & SB21

From: John Hunt <jbhunt@prodigy.net>
Date: Wed, 21 May 2003 22:20:25 -0400
To: "Stapler, Carol" <carol.stapler@leg.state.nh.us>
Subject: Re: SB 110 Minority Report

on 5/21/03 12:33 PM, Stapler, Carol at carol.stapler@leg.state.nh.us wrote:

> SB 110
> Minority Report
> Rep. Matthew J. Quandt
>
> The minority approaches healthcare reform from the perspective that 91% of
> New Hampshire adults and children have healthcare. We are the healthiest
> state in the United States. Further, 76% of those insured receive their
> insurance from their employers who are in the small group market.
> Therefore, when altering the small group market any legislation should do so
> from the premise of not reducing the amount of insured. At the heart of the
> legislation is underwriting and the ability of insurers to manipulate the
> risk pool. In the case of SB 110 it will be easier for insurers to
> segregate the healthy from the unhealthy. The proponents of this bill say
> that these changes will create competition amongst insurers and therefore
> drive down premiums. Upon exhaustive hearings and a plethora of information
> provided to the committee, there was not evidence that there would be a
> decrease in premiums. The best that the proponents could say was that
> premiums would not go up as much and there would be new products introduced
> into the market. The minority felt that an unintended consequence could be
> an increase in uninsured. Further, the bill does not address the underlying
> costs that are driving healthcare-utilization and administration.
> Recognizing the importance of the legislation and the need to create
> appropriate competition, the minority felt that the bill should be retained
> and worked on in combination with two other bills retained by the committee,
> HB 265 and HB 652 which address the cost drivers of healthcare.
>
>

Carol, Please note it is HB652.

JBH

5/27/2003

SB 110

Rep. Matthew Quandt for the **Minority** of Commerce: The minority approaches healthcare reform from the perspective that 91% of NH adults and children have healthcare. We are the healthiest state in the US. Further, 76% of those insured receive their insurance from their employers who are in the small group market. Therefore, when altering the small group market any legislation should do so from the premise of not reducing the amount of insured. At the heart of the legislation is underwriting and the ability of insurers to manipulate the risk pool. In the case of SB 110 it will be easier for insurers to segregate the healthy from the unhealthy. The proponents of this bill say that these changes will create competition amongst insurers and therefore drive down premiums. Upon exhaustive hearings and a plethora of information provided to the committee, there was no evidence that there would be a decrease in premiums. The best that the proponents could say was that premiums would not go up as much and there would be new products introduced into the market. The minority felt that an unintended consequence could be an increase in uninsured. Further, the bill does not address the underlying costs that are driving healthcare --- utilization and administration. Recognizing the importance of the legislation and the need to create appropriate competition, the minority felt that the bill should be retained and worked on in combination with two other bills retained by the committee, HB 265 and HB 653 which address the cost drivers of healthcare.

