Amendments

Sen. Prescott, Dist 23
March 24, 2003
2003-0960s
01/09

Amendment to SB 110

Amend RSA 420-G:2, XVI(a) as inserted by section 4 of the bill by replacing it with the following:

XVI.(a) "Small employer" means a business or organization which employed on average, [~~one~~] ***2*** and up to [~~100~~] ***50*** employees, including owners and self-employed persons, on business days during the previous calendar year. ***"Small employer" shall also include self-employed persons who had small employer coverage on June 30, 2003 and, since then, have continuously maintained small-employer coverage through the exercise of renewal or replacement rights under RSA 420-G:6, V or VI.*** 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. ***With prior notice to the commissioner, a health carrier may elect to treat all self-employed persons as small employers.***

Amend RSA 420-G:4, I(e)(7) as inserted by section 5 of the bill by replacing it with the following:

(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; changes in the rating factor for group size; or changes in the rating factor for attained age of covered persons. This subparagraph shall expire on September 1, 2005.

Amend the bill by replacing all after section 6 with the following:

7 Small Group Coverage Renewal and Replacement Rights Extended to Certain Self-employed Persons. RSA 420-G:6, V is repealed and reenacted to read as follows:

V.(a) Health coverages subject to this chapter shall be renewable as follows:

(1) Individual policies shall be renewable to all individuals, regardless of age or eligibility for medicare.

(2) Small group policies shall be renewable to employees and eligible dependents at the option of the small employer and to self-employed persons who had small-employer coverage on June 30, 2003 and who have continuously maintained small-employer coverage through the exercise of renewal or replacement rights under RSA 420-G:6, V or VI.

(3) Large group policies shall be renewable to employees and eligible dependents at the option of the large employer.

(b) The right of renewal under this section shall not exist when the following circumstances apply:

(1) Nonpayment of required premiums.

(2) Fraud or intentional misrepresentation on the part of an individual or an individual's representative, or on the part of an employer, employee, dependent, or an employee's representative.

(3) Failure to meet the minimum employee participation number or percentage requirement of the health coverage.

(4) The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.

(5) The employer medically underwrites or otherwise violates a provision of this chapter.

(6) The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

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) 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.

9 Repeal. The following are repealed:

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

II. RSA 420-G:8, I-a, relative to open enrollment periods.

10 Effective Date. This act shall take effect July1, 2003.

Insurance
March 26, 2003
2003-0993s
01/05

Amendment to SB 110

Amend RSA 420-G:2, XVI(a) as inserted by section 4 of the bill by replacing it with the following:

XVI.(a) "Small employer" means a business or organization which employed on average, [~~one~~] ***2*** and up to [~~100~~] ***50*** employees, including owners and self-employed persons, on business days during the previous calendar year. ***"Small employer" shall also include self-employed persons who had small employer coverage on June 30, 2003 and, since then, have continuously maintained small-employer coverage through the exercise of renewal or replacement rights under RSA 420-G:6, V or VI.*** 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. ***With prior notice to the commissioner, a health carrier may elect to treat all self-employed persons as small employers.***

Amend RSA 420-G:4, I(e)(7) as inserted by section 5 of the bill by replacing it with the following:

(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; changes in the rating factor for group size; or changes in the rating factor for attained age of covered persons. This subparagraph shall expire on September 1, 2005.

Amend the bill by replacing all after section 6 with the following:

7 Small Group Coverage Renewal and Replacement Rights Extended to Certain Self-employed Persons. RSA 420-G:6, V is repealed and reenacted to read as follows:

V.(a) Health coverages subject to this chapter shall be renewable as follows:

(1) Individual policies shall be renewable to all individuals, regardless of age or eligibility for medicare.

(2) Small group policies shall be renewable to employees and eligible dependents at the option of the small employer and to self-employed persons who had small-employer coverage on June 30, 2003 and who have continuously maintained small-employer coverage through the exercise of renewal or replacement rights under RSA 420-G:6, V or VI.

(3) Large group policies shall be renewable to employees and eligible dependents at the option of the large employer.

(b) The right of renewal under this section shall not exist when the following circumstances apply:

(1) Nonpayment of required premiums.

(2) Fraud or intentional misrepresentation on the part of an individual or an individual's representative, or on the part of an employer, employee, dependent, or an employee's representative.

(3) Failure to meet the minimum employee participation number or percentage requirement of the health coverage.

(4) The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.

(5) The employer medically underwrites or otherwise violates a provision of this chapter.

(6) The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

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) 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.

9 Repeal. The following are repealed:

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

II. RSA 420-G:8, I-a, relative to open enrollment periods.

10 Effective Date. This act shall take effect July1, 2003.

Committee Minutes

m

Date: March 8, 2003
Time: 9:15 AM
Room: LOB 101

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

SB 110 relative to small group health insurance coverage.

Members of Committee present: Senator Flanders
Senator Prescott
Senator Cohen
Senator Martel
Senator Roberge

The Chair, Senator Robert B. Flanders, opened the hearing by calling upon the Prime Sponsor, Senator Russell Prescott.

Before we begin, if I may, I'd like to set down a couple of reasonable rules. We have so many speakers today I'm going to ask you to hold your remarks to three (3) minutes. If not, we'll be here until late, late tonight. If your point has already been made, I would ask that you not repeat it because there are many, many speakers. I apologize, we tried to get a larger room today and the House wouldn't give us a room, so we have to stay here. Again, I apologize for that. Senator Prescott?

Senator Russell E. Prescott, D. 23: Written testimony handed in. ***See Attachment A.***

Senator Robert B. Flanders, D. 7: Any questions of this witness? Senator Cohen?

Senator Burton J. Cohen, D. 24: Thank you. I know there are a lot of people to testify but I've heard from a lot of my constituents on this bill, probably more than any other bill this session so far, and most of them have been small businesses who are **opposed** to the bill. One of the concerns that's been raised is – and perhaps you can answer this – is does it pass the buck forcing the employer, the small business person, to ask a lot of personal, medical questions themselves about the employees and then be the discriminatory party themselves?

Senator Russell E. Prescott, D. 23: As not being an insurance agent, not knowing what questions are asked, I would defer that question.

Senator Burton J. Cohen, D. 24: Alright.

Senator Robert B. Flanders, D. 7: Any other questions? If not, thank you for your testimony. Governor, do you wish to testify?

Governor Craig Benson: If you don't mind. If not, I'll just come by and say hello. Thanks, Mr. Chairman. Thanks for the opportunity to be here. I'd like to make just a few brief comments about Senate Bill 110.

As you probably know, I've spend a lot time campaigning throughout this State and one of the things that I heard repeatedly from the many, small businesses in this State that the cost of insurance had become untenable for many of them, forcing them to make some very tough decisions. In some cases, they were talking about cutting back their benefits and in

some cases eliminating their benefits for healthcare for their employees because they could no longer afford to pay for them. The cost this year is expected to rise 20% all by itself.

To put this all in context, we are the second most costly state to write health insurance for an entire Country, yet, we're the healthiest state in the Country. So we have a huge disconnect of where we should be to where we are. This needs to be rectified. Senate Bill 110 makes a powerful step towards trying to reform what needs to be reformed in a big way.

If we don't do something about this soon, small businesses make up about 98% of all businesses in the state of New Hampshire, we will put them in a position where they no longer will be writing healthcare coverage. We will have a large number of uninsured in this State and we will no longer have a really viable insurance market in the state of New Hampshire.

So, I think it's important for us to move swiftly and rectify this situation in the State to put us where we should be. I'm proud that we are the healthiest state in the Country. Our healthcare rtes should reflect that and with this reform, reforming the CON and also finding ways in which we can reform malpractice, I think we can go a long way to getting this insurance problem behind us. Thank you for your time.

Senator Robert B. Flanders, D. 7: Thank you very much. I will go back to recognizing sponsors. Senator Clegg? He is not here. Representative Carter?

Representative Mark Carter, Hills. D. 44: Distinguished members of the Insurance Committee, for the record, I'm Representative Mark Carter from Peterborough. I represent District 44, which Peterborough, Sharon, New Ipswich and Greenville. I'm appearing today with Philip Grisofi of Greenfield, New Hampshire, a friend of mine and an insurance industry professional.

I will try to give you the expedited version of my remarks in order to accommodate the Committee as requested.

Senator Robert B. Flanders, D. 7: Thank you.

Representative M. Carter: Written testimony handed in. ***See Attachment B.***

Mr. Chairman, with your permission, Mr. Grisofi has a very brief statement and then I have an amendment to offer and brief testimony on that amendment.

Senator Robert B. Flanders, D. 7: Yes.

Mr. Philip Grisofi, M&M Associates: I signed up to speak so you can this time – I'm generally in support of SB 110. I think the change in the definition to 2 to 50 makes a lot of sense for the State. As we've seen in other states, it seems to work. However, I just think that we need to make sure that when we look at the medical underwriting issues, we make sure we've taken everything into account that other states have tried and that we just try to make sure that we don't have unintended consequences as we move this along. But, in general I'm definitely in favor of the bill as it's written.

Representative M. Carter: I'm passing around copies of an amendment, 0142h. If I could just wait for everybody to have that in your hands. ***See Attachment C.***

Senator Robert B. Flanders, D. 7: Yes, go ahead.

Representative M. Carter: Begins reading from written testimony handed in. ***See Attachment D.***

Senator Robert B. Flanders, D. 7: Any questions of these witnesses? If not, thank you very much for your testimony. Senator Clegg?

Senator Robert Clegg, Jr., D. 14: Thank you Mr. Chairman, members of the Committee. I'll be brief. As many of you know, yesterday I spoke at the Press Conference about certain tactics by monopolistic companies in the state of New Hampshire. I will tell you – I will ask you first to keep as much out in the public as possible, do consistent press releases because last night a 74-year –old woman who still owns her business told me she received a call from her insurance carrier saying that if Senate Bill 110 went through, she could no longer buy supplemental insurance through her Medicaid benefits. I think those tactics are wrong and disgusting and despicable. So, I ask that.

Obviously I'm in favor of the bill. I know you have a great number of people to testify. I also want to point out that the basic premise in Senate Bill 110 is the same bill that Anthem Blue Cross supported in Colorado just a week ago. So, I know that Anthem Blue Cross has come out strongly with a number of letters saying that it isn't good and I'd ask that you ask the question *"if it's good for Colorado, why isn't if good for New Hampshire?"* I'll take any questions if there are any, other than that...

Senator Robert B. Flanders, D. 7: ....questions for this witness? If not, thank you for your testimony. Senator Morse? No. Are there any other sponsors or cosponsors of the bill present? If not, I will recognize Commissioner Rogers.

Paula Rogers, Commissioner, NH Department of Insurance: Thank you, Senator Flanders. Good morning, members of the Committee. For the record, my name is Paula Rogers and I'm the Commissioner for the Insurance Department and I spoke with Senator Flanders before the hearing began and what we would like to be able to do is after I have completed my brief comments, Leslie Ludtke give the Committee a snapshot of the insurance market as it exists today, because as you seek to evaluate the bill before you, I think it's important that you have background information. Then additionally, Alex Feldvebel, Deputy Commissioner, would like to speak briefly about the Department's analysis of the bill.

Senator Cohen mentioned something I think is really important. He indicated that the bill had drawn more calls than any other bill this session and you can see from the audience in the background that it is a matter of huge significance to people.

We at the Department, if we receive calls of a certain kind, we can definitely tell you one of the most frequent calls in the area of health insurance is – well, there are two points that consumers bring up, purchasers also, not enough carriers to choose from and the cost is too high.

The bill before you is a bill that actually, I think is quite well drafted to achieve the goals that the sponsor and proponents seeks to achieve. In fact, I commend the sponsor and those people who are working with the sponsor that a bill has been brought to the Committee that technically, I think, is very sound. I think that's important because if the bill is technically sound and I know there are some amendments that have been proposed, then we can sort of move to the next layer of analysis which is what does this bill do to the marketplace?

You've heard reference to what happened in 1995, and at that time Governor Shaheen, then Senator Shaheen, mentioned the fact that there would be concerns that the bill, in 1995, would have adverse effects in the marketplace. It would create a new pricing structure in the marketplace.

Well, the bill before you will do the same sort of thing. It will basically allow insurers to utilize factors that they have been prohibited from utilizing for the last several years. So, you need to, when you listen to Commissioner Feldvebel, understand that what the bill is doing is saying to insurers *you have not been able to use health; you have not been able to use geography; you have not been able to industry type, and you've been restricted on rating for age.* Those will change under the draft before you.

The other thing the bill will do will be to provide a new definition of group size. Now, both the introduction of new factors and the change in group size will mean that all of your constituents who presently carry health insurance in a fully funded capacity will see that the bill may have affects on their pricing. A large group in the middle will probably see no affect, but there will be out layers who will see favorable affects and those that will see less than favorable affects. I think you as individuals looking at the bill need to be prepared to understand what those effects will be.

The long-term interest of the proponents, of course, is to bring in new carriers. Bringing in new carriers would heighten competition certainly around traffic design. I think that is really the thrust of the bill the proponents are bringing forward. Price pressures are very difficult to address. I think reducing pressure on the premium is a worthy goal but I think it's probably unrealistic as you look at this bill to believe that prices will come down significantly. What you may be able to do is to relief pressure on pricing.

So, I'm actually going to turn to Leslie Ludtke, who I have asked to come forward just to give you the backdrop of what is the market we're talking about. What is this regulated market and does the rest of the health financing system look like, who are a the people in the marketplace that would be affected by the bill?

Senator Robert B. Flanders, D. 7: Good monring.

Leslie Ludtke, NH Department of Insurance: Good morning. My name is Leslie Ludtke. I'm a Health Policy Analyst with the Department of Insurance. I have a fact sheet, which I hope will be of use to the Committee members. ***See Attachment E.*** Along with the fact sheet, I also have some graphs that depict some of the areas addressed in the fact sheet. ***See Attachment F.***

As the Commissioner said, in evaluating the legislation, I think it's important to have just a very general understanding of what the market looks like. What I've done in the fact sheet is address six specific areas.

Begins reading from Attachment E. *(turn over tape)*

...to prepare this, what I did was gathered information that had been generated in a number of different areas. The Department collects information on its statutory filings. It collects information on a supplemental report. Recently, the Department of Health and Human Services conducted an employer based survey and prepared a report – the HRSA Report – which addresses the employer based insurance market. I also looked at national data as well and what I tried to do is make a very simple list of what I consider to be the most important insalient facts in each of these areas.

I think that the fact sheet is largely self-explanatory and I would invite the members of the Committee to go through the sheet, take the graphs and look at the graphs at the same time. The graphs basically follow the presentation in the fact sheet.

Let me point out just a few items which I think are of particular importance in the fact sheet.

First, there's a high level of employer based insurance group in New Hampshire. As noted in the group markets first bullet, nearly 90% of non-elderly insured adults obtain coverage through employer-based insurance compared with 76% nationally. So, New Hampshire has a very high reliance on the employer based insurance group market.

Second point, I think if you look through this you'll see the specific data. Actually, I attached at the end the specific percentages but most businesses in New Hampshire are small businesses. That's not to say that most employees are employed by small businesses but most businesses are small business. You'll see a breakdown of the number of small businesses.

Third point, there are more self-insured businesses in the large group market than there are in the small group market. You'll see on the numbers here that a very, very high percentage of people in New Hampshire obtain insurance through self-insured market, which is not regulated by the State. There's about 300,000 people that do that and most of them are large businesses. The small group market has about 181,000 people in it. Most of the people in the small group market are in the groups 1 through 50.

I think this is an important point and this is a point that is really based upon the supplemental report that we received last year. The premium costs are comparable in the small group and large group markets over the whole market. The average per member, per month premium cost is about $2.00 more per month in the small group market than it is in the large group market. So, the premium cost in the markets appear to be fairly comparable.

I think the last thing is a very important point and that is, premium costs are very difficult to compare and you'll see this is the fact sheet. There's a couple of pages devoted to an attempt to compare premium cost. I think what you'll see is first of all, depending on what reports are looked at, the premium cost differ among reports. The premium costs that we find in our supplementary report differ from those in our statutory filing. The federal reports are largely based on per employee, per month cost. Ours are per member, per month cost. So, there has to be an adjustment on there.

I think another point that ought to be focused on in comparing premium cost is that different products may be offered in different states and different products may be offered in different markets. So, when you're comparing the cost of two items, you don't have confidence that the items that you're comparing are like items. I think that presents another difficulty in comparing premium cost.

So, that's it in keeping with the time limitation and I'd be happy to take any questions you might have.

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not, thank you for your testimony. Alex, please.

Alex Feldvebel, Deputy Commissioner, NH Department of Insurance: Thank you, Mr. Chairman, members of the Committee. I'd like to hand to the Committee another

information piece, which is our analysis of the bill and we have extra copies of that. ***See Attachment G.*** For the people here today, if you call the Insurance Department, you can get extra copies of anything that we've handed out today. Here's extra copies of our analysis.

Begins reading from Attachment G. We have indication that a number of insurers would be likely to come into the market based on the increased underwriting flexibility.

Another consideration that you have to pay attention to is share numbers of players in the market doesn't necessarily have a big impact on competition. What you need to increase competition is numbers of players in the market who have significant market share. So you can have a lot of players and still only a few with most of the market. So, the question you have to ask is *are these new players likely to garner significant market share?* The chief obstacle to that, these days, has been getting competitive contracts with healthcare providers. And, so, we don" know whether that barrier will still be a significant impediment to increasing competition.

Begins reading from Attachment G, page 2, #2. So, in other words, the immediate effect will be it will create some winners and losers in terms of how they come out with the rating factors being applied to them. What we tried to do, based on information from our supplemental report that we got for the first time last year, is to create a picture of how many people are likely to go up by how much, and how many people are likely to go down by how much in their rates? So, basically, what we did is we developed an actuarial model, which you see at the back of your reports. So, if you could whisk through that briefly.

There's two charts which take all of the rating factors into consideration. The first one, labeled **Impact of Small Group Reform on Current Rates**. This chart attempts to answer the question *if the rules were changed last year, where would everyone be today relative to where they are?*

If you look at sort of the middle bar in this chart, it has 0% at the bottom. What this shows you is that about 12.5% of groups would have no change in their rates.

If you go to the right, the one that says 10%, it shows you that about 26% of groups would experience a 10% increase.

Look to the left, a similar number, about 26% of groups would experience a 10% decrease.

Then as you go out to the higher levels of increase and decrease, you notice the bars get shorter so that groups experience a 20% increase would amount to just shy of 10% of all the groups. Groups with a 30% increase, about 2% of all groups.

That is – this chart answers the question *if the rules were changed last year, where would everyone be today?*

Another question I want to ask is *well, what's likely to happen next year?* That's the other chart, so flip the page.

The question of what's going to happen next year, you have to factor in trend, which we've assumed at about 12.5%, which is just the increase due to inflation in many healthcare sectors.

So, this gives you, if the bill passes this session, who are going to be the winners and losers next year and by how much. It gives you an indication of the percentage of groups that will

experience increases or decreases and gives you an idea of how much rate variation is likely to occur attributable to these factors. By the way, this model does incorporate the caps that are put in under the legislation.

I'm basically out of time, so let me try to make a couple more points.

One of the possible beneficial impacts of this legislation is that it may encourage self-funded groups to come back into the small group market. Right now, groups that relatively healthy in the small group market have the option of moving into self-funded status and then coming back when their health experience gets worse. If you have greater rating flexibility, there's a flexibility of drawing some of the self-funded back into the fully insured market.

This is particularly concerning given the fact that at the federal level there's legislation being considered that we create what's called *the Association Health Plans*, which is legislation that will allow a number of small groups to get together in New Hampshire and be rated outside of the small group market. Under our current rules, there's a danger if such federal legislation were to pass in that the healthier groups would be able to get together, get out of the small group market and be rated separately, leaving the higher risk folks in the small group market and increase upward pressure on rates in the small group market.

So, we've been concerned and the National Association of Insurance Commissioners have been concerned about the possibility of negative impact of association health plans on the regulated small group markets. If additional rating flexibility were introduced, that would to a certain degree inoculate New Hampshire's market against that phenomenon because insurers would already have the rating flexibility and there wouldn't be the need to escape market restrictions.

One of the other considerations is on geographic rating. We've had a number of complaints from insurers about the un-level playing field that is created by our current market rules. Un-level playing field between insurers that make a commitment to offer coverage statewide and insurers that haven't been able to do that as yet but only cover part of the State. What happens is insurers that only cover part of the State are able to offer their coverage in lower cost areas of the State and therefore have an arguably unfair competitive advantage against the insurance who offer state-side coverage. So, there is pressure on the insurers who offer state-wide coverage to shrink so that they can complete more effectively with the insurers that don't offer state-wide coverage. That certainly would not be good for competition in this State.

So, by shrinking the definition of small group and permitting geographic rating, you do create more of a level playing field and you tend to decrease the chance of insurers shrinking from state-wide coverage.

One final consideration is what when we do our analysis of what's driving premium increases, we see that the driving factor is basically increasing medical claims cost while using more healthcare and the healthcare that we're using is costing more. That's the main driver. What this legislation does, doesn't directly address that, so what we're saying is this can't be regarded as the "silver bullet" in terms of affordable of health insurance. We have to – whatever we do here, we have to continue to pay attention to increasing medical plans cost and ways that we can address that. We think there are a number of measures that New Hampshire could take and have been taking to address that concern.

Senator Robert B. Flanders, D. 7: Any questions? Senator Cohen?

Senator Burton J. Cohen, D. 24: Thank you very much. Very helpful information, thank you for presenting this. I have not been on the Insurance Committee before, so this is somewhat new to me but my question – I guess is more from a layman's position based on that – is, I wonder if passage of this bill could result in – I hate to use the word – "discrimination" but I can't think of another word based on the size of the group, on geography and on industry? In other words, would this enable insurers to "cherry pick"?

Deputy Commissioner Feldvebel: Well, when you introduce rating factors for geography, health status, that is by definition kind of discrimination in a sense you're going to treat groups differently based on those factors. You have to use the word discrimination there in a non-majoritive way.

Senator Burton J. Cohen, D. 24: Right.

Deputy Commissioner Feldvebel: The issue of – I don't use the word "cherry picking" anymore because it's sounds sort of loaded. (laughter) What it will do is increase the incentive for insurers to compete based on risk selection and you do want to ask the question, *what kind of competition do we want to encourage in the market? Competition based on quality cost effectiveness or competition based on selection of the best risks?*

There are different kinds of competition just like there's football and baseball or different rules of engagement and it is a relative question you do want to pay attention to what kind of competition you're promoting in the market and what would be the overall impact of that competition? What this bill is attempting to do is to strike a balance between insurers' interest in having the underwriting flexibility really needed to rate groups in a way that they can feel comfortable and overall access to affordable coverage. So, it's really a question of striking the right balance.

Senator Robert B. Flanders, D. 7: Senator Prescott?

Senator Russell E. Prescott, D. 23: Thank you. You mentioned a very complex market... hard to forecast. Is there an opportunity when a group would receive an increase in their premium that they could use that as an opportunity to move to another insurance company, if there was one in New Hampshire, and move to a different product, if there was a different product in New Hampshire? Could Senate Bill 110 offer that fact that they could move to another company, move to another product and in fact without being locked into premium increases, lower their premium increases by going to another product or company?

Deputy Commissioner Feldvebel: Yes, that's likely to happen. As – some groups get the rate increases that are sort of more than others, they're going to take a better look at the product design and what their choices are. There's likely to be more movement, too many insurers and more pressure and interest in new products and certainly less likely to have a beneficial effect in terms of competition in pursuing some of these new product designs that the Insurance Department has been in favor of.

Senator Russell E. Prescott, D. 23: Very good.

Senator Robert B. Flanders, D. 7: Any other questions? If not, thank you for your testimony. Now, I'm going to through the lists and start at the top with Thomas Welden? I apologize, some of us will be leaving and coming back. A lot of us have some other bills that we are sponsors of and we need to introduce in other hearings. Also, Senate Bill 174 will be postponed until next week. So, if anybody comes in or is waiting for that, please tell them we will open the hearing and close it and we'll discuss it next week. Thank you.

Thomas Welden, Eaton & Berube Insurance Agency: Written testimony handed in and read. ***See Attachment H.*** (change tapes)

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not, thank you very much for your testimony. Lisa Carroll?

Lisa Carroll, Small Business Service Bureau: Written testimony handed in and read. ***See Attachment I.***

Earlier there was testimony that – I wrote down the number so forgive me if I wrote them wrong – but, right now there is a high reliance on the employer based health insurance market in this state. I disagree that previous legislation has not worked. I think it has worked. I think it has expanded access and availability. No one ever claimed, in any state, that health insurance reform would improve affordability of care. Affordability is an issue that goes beyond the insurance market; it has to do with provider contracting. It has to do with utilization of services and what I see in this bill is that people will actually be punished for utilizing those services because it will cost them more in the long run.

I'm willing to answer any questions and I appreciate your time.

Senator Andre Martel, D. 18: Thank you, Ms. Carroll. Any questions? Thank you very much for coming. Our next speaker is Raymond White?

Raymond White, NH Association of Insurance & Financial Advisors: My name is Raymond White. I'm a small business specialist in benefit plans. I own Cornerstone Benefit and Retirement in Bedford, New Hampshire. I'm speaking today on behalf of New Hampshire Association of Insurance and Financial Advisors as their Health and Employee Benefits Chairman.

I do have a presentation and in trying to stay with the time, I'm going to skip to the back pages but I would like to point out that this presentation contains a lot of the factual information that's be alluded to by Senator Prescott when he introduced the bill and some of the other speakers. So, if you're looking for backup material in terms of where do these statistics come from and where do these numbers come from, it's all in this package.

Again, in the interest of time I would like to just move to page 21 in the back of this presentation and just talk about a couple of the advantages that would occur if this legislation were to pass as well as debunk some of the criticism we've heard previously. ***Begins reading from Attachment J, page 21 and 22.***

If I can just get you to turn back to page 18, we produced a graph that shows that there are safety mechanisms built into this law to prevent an insurer from abusing its clientele. This is according the National Association of Insurance Commissioners model. What happens is an index rate is filed. For the sake of my illustration, we'll call that $100. An insurance company is then allowed to rate up or down, plus of minus 25% based on that base rate. So in other words, they can charge an extremely unhealthy group $125. They could charge an extremely healthy group $75. Once that occurs, they are not going to be allowed to go back to the well except with a 15% maximum renewable increase. So, for instance, the group that was brought in – and I'll even use the term "cherry-picked" as some critics have said – at 75, will not – if they have a big claim or a bunch of big claims occurring in a year, be hit with an increase that brings them all the way to the 125%. The model says you can only raise their rate a maximum of 15% due to health status. Thus, as you can see from our chart, it would

take four years to move from the bottom rate to the top rate. In addition, pegging the maximum rate to the minimum rate prevents an insurance company from "cherry picking" because if an insurance company files a base rate that is too low in pursuit of those young, healthy people, then they are going to – as an adverse consequence – one that they did not intend – actually attract a high age population because all these rates are pegged together. If you move this, the top moves down with it. If you move it up, you become uncompetitive. If you decided you're going to rate defensively and you set an index rate that is too high, saying we've got to get this premium because we're concerned about attracting too many over-aged people, then you're to become uncompetitive to that market you desire the most, which is that younger market. So, this index rate protects this criticism of "cherry picking" because it moves in tandem at both ends of the spectrum.

Begins reading from Attachment J, page 22, #7.

Here's what my experience shows. You've heard testimony that there's pocket in the State that some insurers do not participate in. I've sat in meetings where companies have said *Hey* (to you brokers) *we could add Exeter Hospital tomorrow. We have a contract rate assigned but it's going to cause a 3% rate increase on the entire population of our insurers. Do you want us to do that or don't you?* As brokers we say *No, we don't want you to do that. We're only going to get certain amount of business out of Exeter and I'm going to be having to deliver rate increases to all my groups.* If they were aloud to geographically rate, they could just say *We will add Exeter Hospital and people who are in the zip code will just see an increase.* There are reasonable caps on all of these flexible rating mechanisms that will protect the consumer but at the same time entice insurers to go into higher cost areas without impacting others.

Begins reading from Attachment J, page 22, #10.

For the record, NAFA is against the establishment of AHP's at the federal level because they will allow for what many of the critics have mentioned "cherry picking" because now you'll have plans that are completely beyond the reach and purview of our State of New Hampshire Department of Insurance to set any parameters they want and take groups really under any circumstances. This preserves the control of you, the Legislature, and the Department of Insurance to set reasonable parameters one what companies do, They're all on the same playing field.

Lastly, I'd just turn your attention to this piece, which was done by the National Association of Health Underwriters. ***See Attachment K.*** Once again, the importance of this piece is that it does give you background on what other states are doing, which I think is important.

Again, for the sake of brevity, I'd just like to call your attention to page 9 and the top full paragraph says:

> ***However, NAHU has found a high degree or correlation between states that do not always follow the criteria listed in this paper for successful health insurance markets and state where health insurance producers report a high rate of insurance carrier exodus. Furthermore, in these states we also have seen evidence of higher rates, and higher number of uninsured individuals. As such, NAHU strongly recommends that states allow for the use of medical underwriting in the small-group and individual markets, prohibit business groups of one,*** (which we did with Senate Bill 118) ***create high-risk pools, allow rates to be filed and then immediately used, limit the***

number of mandated benefit requirements, regulate PPO plans appropriately, and allow for the development of effective plan networks. This will keep health insurance rates down, the level of competition high, and the number of uninsured as low as possible. All desirable goals.

I would lastly, in closing, would like to address the issue of groups of 1. I have a lot of experience in that I have a large client base that will be affected as this legislation moves forward on the groups of 1. We have language in the bill or are going to offer an amendment into the bill that will protect groups of 1 during a transition period. But, I want you to understand that when people are allowed to act in their own interest without regard to health insurance, a lot of market abuses occur. I see these almost on a daily basis in my own office. I have clients who will choose to buy a $5,000 deductible individual plan and pay very little premium, then the phone will ring and they'll say *As you know, Ray, I'm an electrician and I'm insured with you. I need to go buy a group plan now because I have surgery coming up next month. I just want the lowest co-pay, highest expense plan I can buy because this is what I have coming up.* They selected against the insurance company.

Also happens with maternity. I get calls weekly where people say *I found out I'm pregnant. I need to enter into the group market where maternity will be picked up.* Sometimes they'll pick up that plan in the 7th, 8th month of pregnancy, deliver the child and drop the insurance or move back into the individual market or whatever. There's a high degree of anti-selection that occurs in groups of 1. That's not healthy and who bares the cost of that is basically the other groups from 2 to 100 or 2 to 50 if we go with this redefinition. Whereas if you worked at a company of 10 employees and they had a $20 co-pay plan and you developed a sickness that was going to require a lot of treatment, the odds are if you went to your boss and said *let's move to a plan that has $5 or $10 co-pay because I've got an issue,* the boss would said *hey, look. This is our plan, you knew this was our plan when you came here. This is our plan.* And they would not be able to select against the insurance company. So, I want you to understand that concept.

I appreciate your time and if anybody has any questions, I'd be happy to answer them.

Senator Andre Martel, D. 18: Thank you very much, Mr. White. Any questions? Senator Cohen?

Senator Burton J. Cohen, D. 24: I wasn't sure I heard you correctly, perhaps you can clarify this, are you suggesting that you would be banking on, relying on the attraction of younger, healthier people into purchasing health insurance and that that is essential to protect the older, less healthy people?

Mr. White: No question. The hardest person for me to insure, at any level, be it life insurance, disability insurance or health insurance, is the young – and I'm not trying to be sexiest but, the young male who is under 30 years old because he perceives *I'm not going to die. I'm not going to be disabled and I'm not going to need health insurance.* That person is essential to have participating in the pool because it protects the rate integrity for everybody else.

Senator Burton J. Cohen, D. 24: Thank you.

Senator Andre Martel, D. 18: Any other questions? Seeing none, thank you very much. You said you were going to bring forward an amendment?

Mr. White: Yes. There's language being worked on with Erik Taylor and Senator Prescott that will be basically tie existing one-man groups into the 25% cap that's in the present bill, just understanding that they will be grandfathered. The purpose of that is groups that now exist as 1 will have a transition period that will last, depending on passage of the bill and so forth, for a year to 18 months where they can't just immediately receive massive rate increases to be chased out of the pool and then have those protections.

Senator Andre Martel, D. 18: Thank you. Would see that we get it as soon as possible? Thank you very much. Next speaker is Beth Roberts? Please people, we're trying to get this done on a 3 minute timeframe. We still have a lot of speakers. Again, we had an issue with the room this afternoon. So, go ahead.

Beth Roberts, Harvard Pilgrim Healthcare: Written testimony handed in. ***See Attachment L.*** I will do my best to keep it under 3 minutes. (turn over tape)

Senator Andre Martel, D. 18: Well done. Any questions? Yes, Senator Prescott?

Senator Russell E. Prescott, D. 23: Concerning that the Health status – Harvard Pilgrim's in other states in the region, any other states in the region that use Health status that you're offering insurance?

Ms. Roberts: No.

Senator Russell E. Prescott, D. 23: What...

Ms. Roberts: In the state of Maine – let me just clarify for one quick minute – in the state of Maine it's something that can be done. However, the ability – the range by which you can increase a premium based on health status and many other things, the cap is so limited that there's no merit to actually doing it. So, I believe the cap – I was looking for Bill Graham – it's like 10% or 15%, which would already – the other flexibility, most folks have opted not to do Health status.

Senator Russell E. Prescott, D. 23: It may be 10% or 15%?

Ms. Roberts: I think. Bill, is that correct?

Bill Graham: I believe that the total band may be between 10% and 15% but I don't believe health status is part of that....

Ms. Roberts: ...okay...

Mr. Graham: ...age and a number of other factors but not health status.

Ms. Roberts: Okay. So, I misspoke. Pardon me. But, not in Massachusetts, we don't do health status.

Senator Andre Martel, D. 18: Any other questions for Ms. Roberts? Thank you very much for your testimony.

Ms. Roberts: Thank you. Good luck.

Senator Andre Martel, D. 18: Our next speaker is George Blaisdell?

George Blaisdell, Hampton Falls: George Blaisdell of Hampton Falls. I'm an insurance broker of 17 years and seeing rates come and go, carriers come and go and my personal standpoint from an insurance broker and having a lot of clients over 50, this would be a wonderful thing. It would be a wonderful thing. I believe the insurance carriers should be underwriters because it's very important that we put that out to the marketplace, that people have to have some responsibility to buy the insurance now and not when they need to adversely selected against the companies.

So, I think this legislation is wonderful and a long time coming.

Senator Andre Martel, D. 18: Thank you. Any questions? Thank you for coming. The next speaker is Bob Nash?

Bob Nash, Independent Insurance Agents & Brokers of NH: Thank you very much, Mr. Chairman. For the record, my name is Bob Nash. I'm the President of the Independent Insurance Agents & Brokers of New Hampshire and we're here in support of Senate Bill 110.

We commend the primary sponsor, Senator Prescott, for developing a vehicle for further discussion on healthcare reform in New Hampshire.

To do nothing will watch costs continue to spiral and product availability and choice decrease. Senate Bill 110 seeks to strike a balance between three major issues: increased underwriting flexibility, which will historically lower rates and provide for more product choice; a sensitivity to rates; and, I think a component that we overlook and that is the social component of healthcare reform in New Hampshire; that this Legislature as a policymaking body has an obligation to provide the best possible environment that will make availability insurance coverage for the vast majority of the citizens of New Hampshire. The current system is not working. The current system is seeing the uninsured increase. The current system sees rates continue to go out of sight between 10% and as much as 40% a year and to do nothing is worse than taking Senate Bill 110, as a viable vehicle, and try to develop the appropriate reforms in the system.

Let me point out to you that in our opinion rates should not be the only criteria. Although, that will be the criteria that gets the most attention. But, what we can do with rates is we can never guarantee they will go down but we can guarantee that public policy can do everything that it can do to alleviate the upward pressure on rates.

Just the other day, to the Judiciary Committee, we reported unfavorably a bill that would have expanded the loss of opportunity doctrine in medical malpractice suits. That is a prime example of relieving upward pressure in the healthcare system.

DOI modeling that has been spoken of by Deputy Commission Feldvebel, points out that about 48% of the folks will receive decreases under this bill, approximately 13% will remain the same and approximately 38% will receive some sort of an increase. But out of that 38%, 26% of that 38 will be 10% or less. Guaranteed issue and guaranteed access to healthcare in this State will not be effected.

We have one thing that we did not have 7 years ago and that is we have a high risk pool that in our opinion we should coordinate sufficiently with high risk pool and those individuals that fall through the cracks, that cannot be underwritten in New Hampshire and make sure that the guarantee issue in the high risk pool is satisfied.

I'm going to suggest to you that the passage of Senate Bill 110 with some amendments that have spoken of today and some additional law revisions, which I will address in just a moment, would do two things: Number 1, it will provide pricing and allow the underwriters to price their risk appropriately and it will also provide additional product availability and design.

Mr. Chairman, we would urge the Committee in their deliberations to look at the caps established in the bill to make sure that they're appropriate and to see if they may not be moderated over the course of time to come in on a more tiered approach.

We would certainly urge you to look at the groups of 1, which is a major concern to us and to take a look at whether that should be optional issue or whether we should expand the transition time to eliminate groups of 1 and allow the individual marketplace to catch up so that the huge rate increases with the passage of this bill will not be assumed by the individual that leaves the group market.

But, just as importantly, we think this bill should address the issue that has not been addressed at this point and that is appropriate disclosure by the insurers of cost, rating methodology and loss information so that the employer may make reasonable judgement on what type of group policies and health coverage they would like for their employees.

Most importantly, we should make sure the risk pool is established as a clearinghouse and is obligated to cover those individuals that cannot be underwritten.

With that, Mr. Chairman, I believe Senate Bill 110 is the appropriate vehicle and as Senator Shaheen pointed out years ago in support of this issue, that this is an ongoing process and we have seen in the past 4 to 5 years that it is time to once again reform the system and move forward.

We would hope that this Committee would report this bill favorably with appropriate revisions and we offer our Associations expertise, if needed, to help ensure that that occur. Thank you, Mr. Chairman and I will be more than happy to answer questions if I can.

Senator Robert B. Flanders, D. 7: Any questions? If not, thank you for your testimony. Yvonne?

Any questions? If not, thank you for your testimony. Yvonne?

Yvonne Nanasi, Anthem Blue Cross and Blue Shield: Thank you very much, Mr. Chairman, members of the Committee. I'm Yvonne Nanasi, the Director of Government Relations for Anthem Blue Cross and Blue Shield. It seems to be a name that you hear a lot in Committee these days. (laughter) Yes, we are here opposed to Senate Bill 110.

I will be very brief in my remarks since my written testimony does pretty much explain what our analysis of the bill has been. We have done some detailed analysis regarding the impact of Senate Bill 110 on our groups. As you know, we are – and we are proud to be – the largest insurer in the State and we do offer a wide variety of products both in the individual and the small group and the large group market, which is **WHY** we are one of the largest insurers of the State.

What's our problem with Senate Bill 110? First of all, we had comparents of the Keyser Foundation data and I want to point out to you briefly a chart that appears on about the 4th page of the packet passed out and what this chart does is show you the percentage of

employers offering coverage with under 50 employees. It compares the states that have community rating, like us, with those that have the plus or minus 25% rating band, similar to Senate Bill 110. As you can see from that chart, the states that have community rating have significantly higher percentage levels of coverage in the small group market. There's a reason for that.

Our concern with Senate Bill 110 is that, yes, it may do some good for some employers but we are very worried that the hurt for others will be significant. Those that are located in the Seacoast and the North Country regions where we know the cost of medical care is higher. Businesses with employees over 60 years old and because of the age band increases could have their rates increase by over 13% in the first year that this goes in to effect.

Businesses with employees or their dependents with health conditions; diabetes, asthma, high blood pressure, cancer, HIV, heart disease. These employers don't know they've got these individuals in their workforces right now or in their families of the workforces. They don't know that that will impact their rates.

To give you a little bit of flavor about what health status rating is all about, in the back of the packet there are 3 examples of what is a health status questionnaire.

What will small employer employees be required to fill out? Most likely, when health status rating goes into effect, these are the type of forms, these are the types of questions that employees will be asked and have to provide truthful information. It goes into their family and their member's medical history. In fact, I ran over form that was 8 pages long. These are basically the most common ones.

Businesses overall that qualify under one or more of these rating factors over the next 3 years, we believe, could see a 65% to 72% increase, which is no small fee for a small business these days.

Senator Burton J. Cohen, D. 24: I'm sorry, who would see that increase?

Ms. Nanasi: We believe that the top end would be 65% to 72% over a 3 year period because what you can do is you can increment this out and hopefully you would.

We don't believe there's that much wrong in the New Hampshire small group market right now. There are MSA's being offered. There is differentiation of products that are coming forward.

We believe that the route to go is not turning back the clock to pre-1994 and going back to back to underwriting.

We believe that disease management programs can help lower the increase in cost just as effectively and perhaps more effectively manage diseases and those that are ill than underwriting will.

We stand ready to assist you with this bill. We believe there are other alternatives out there and would be happy to help as you continue your deliberations. Thank you very much.

Senator Robert B. Flanders, D. 7: Any questions of this witness? Senator Prescott?

Senator Russell E. Prescott, D. 23: Thank you, Mr. Chairman. In Colorado, there's this same situation that's going here in New Hampshire, rate bands there are being suggested

(cough) and testified by Anthem Blue Cross and Blue Shield in favor of. What is the difference? Because community rating in Colorado isn't working there as it is not working here and I'm trying to find out why Blue Cross is against in New Hampshire and for it in Colorado.

Ms. Nanasi: We would beg to differ that community rating is working in New Hampshire. We do believe that. We believe that it's provided for more availability for small employers to, in a sense, retain healthcare insurance because the risk is, in a sense, spread across the whole state and we believe that our demographics and our market is different that Colorado.

Anthem does offer different products in different states, basically to meet the needs of those markets. We don't believe that going back to pre-94 will improve – we'll call it – the market in New Hampshire any more to bring – we'll call it – any better products in, in terms of products that have less deductibles or more coverage. That's not the kind of products we believe you're going to see. We believe you're going to see higher deductibles and less coverage. The types of things that are focused on a younger, healthier market to attract those folks and yes, "cherry picking".

In Colorado, they don't believe – they're in a different point in their market right now and when I sat down with the Colorado people and we basically batted out the differences that we had in the State, it became very apparent why we needed to take two different positions.

The Colorado plan is also – we'll call it – much more used to underwriting and knows very well what some of their risks are. We aren't – we don't know what those risks are out there which is why we fear for some of our small employer groups.

Senator Robert B. Flanders, D. 7: Further questions?

Senator Russell E. Prescott, D. 23: Yes. I know that 60% of the market is Blue Cross and Blue Shield. I read some things concerning that. You have a lot of business here in New Hampshire. What is the market share in Colorado?

Ms. Nanasi: I can check on that for you. Actually, to be quite frank, the 60% kinds of goes back and forth depending on who has the State contract. (laughter) That's a big chunk of change in New Hampshire. (laughter)

Senator Russell E. Prescott, D. 23: How is New Hampshire not used to underwriting? Is it just because of 1994 and the increases in the insurance costs we've had?

Ms. Nanasi: Since – keep in mind, Blue Cross and Blue Shield, prior to 1994 – well actually, more likely prior to 1993, we were the State's insurer of last resort. Blue Cross and Blue Shield of New Hampshire really never practiced underwriting, which is what got us into the trouble we got into in 94.

Since then, of course, our purchase by Anthem, we are not a non-profit company anymore nor are we the insurer of last resort. We pay premium tax and everything else that the State wants to bring upon us including assessments for high risk pools.

So, underwriting would be a new venture for us. It's not within our corporate personality.

Senator Russell E. Prescott, D. 23: If you were allowed to offer 1 group insurance, would you?

Ms. Nanasi: With the exception of a short hiatus, we have always been in the individual market in New Hampshire.

Senator Russell E. Prescott, D. 23: You would continue to do that?

Ms. Nanasi: We certainly would. We have a very successful individual product in the State. Actually, by virtue of working with the Insurance Department in developing that product and it's selling like hotcakes, we're very pleased with it. We believe it's a viable market.

Senator Russell E. Prescott, D. 23: So, you heard my opening statements where we, as a Committee, need to look at allowing insurers to continue to offer groups of 1 while maintaining the emphasis of Senate Bill 110, 2 to 50 groups so that we can look like 80% of the rest of the Nation to allow more competition in the marketplace and hopefully do what the intent is, to stabilize prices and even offer better products.

Ms. Nanasi: I think, Senator, at the end of the day – and we've said this when this bill has come up in previous years – that the change in definition of group size probably is not the most onerous thing this bill and could be coped with in the market. What really is a radical change is bringing in the underwriting factors and I think that's where we feel there will be severe market disruption for some small employers. Even those over 50, between 50 and 100 employees, many of them are going to be a little surprised when they find out what experience writing is all about, when they have one heart attack or one premature baby in a year your rates aren't that smooth as they are now while you're in the small group market.

So, it's a radical change and perhaps too much too soon.

Senator Russell E. Prescott, D. 23: Just before you (change tapes) NHIIA and they mentioned the same concerns and they wanted to work with that to get that accomplished; a phase-in, a transition period, minimizing rate bands or something similar to that, that's what you're saying as well. Am I hearing that from your as well as from the Independent Agents?

Ms. Nanasi: If you feel that it's good public policy to introduce or go back to underwriting in the small group market, it's probably advisable to look at somewhat of a phase-in or some type of a lesser level of underwriting than is proposed in Senate Bill 110. It's really on the high end.

Senator Russell E. Prescott, D. 23: I have some questions that were written by my Majority Leader. *Have you ever denied coverage for medical care resulting from an insurer's illegal act?*

Ms. Nanasi: I can check. I didn't bring counsel with me today. (laughter) I brought an underwriter but no counsel. Insured is subscribers?

Senator Russell E. Prescott, D. 23: Right. It's an illegal act. He's asking a question *why don't you delete that little caveat that's in your Blue Cross and Blue Shield policy? How did it get put into your policy?*

Ms. Nanasi: Does this mean if somebody smokes in the hallway?

Senator Russell E. Prescott, D. 23: Could have sled through a stop sign and got into an accident and you were denied coverage because it was an illegal act to slide through a stop sign.

Ms. Nanasi: Would you like me to – excuse me for being so presumptuous, Mr. Chairman, but would you like me to take away those questions and address them at a – maybe we could put them together and I can address them at another time? I would be happy to.

Senator Robert B. Flanders, D. 7: Any other questions? I have just a couple, if I may. I'm just curious, I got copies of some of the letter you sent out. Can you tell us how many letters Blue Cross sent out to their policyholders?

Ms. Nanasi: Regarding this issue, specifically?

Senator Robert B. Flanders, D. 7: Yes.

Ms. Nanasi: Or any other issue during this year?

Senator Robert B. Flanders, D. 7: March 18th?

Ms. Nanasi: We informed our small group members – our Vice-President of Marketing – we informed them of the existence and some of the impacts we felt were possible by Senate Bill 110 and that was approximately 5,000 members. We are very invested in the small group market.

Senator Robert B. Flanders, D. 7: Your testimony today is 60% - you do 60% of the business in New Hampshire?

Ms. Nanasi: Approximately.

Senator Robert B. Flanders, D. 7: How much of it is done in the North Country?

Ms. Nanasi: We – what I'd like to do to answer your question and I'll get you the numbers, is I'd like to get you our market percentage in the North Country but I'd also like to get you how many insurers actually insure the North Country. Who really sells up there. We feel pretty responsible for the North Country and we also put a lot of our contribution investment into the North Country.

Senator Robert B. Flanders, D. 7: There's no such thing in my Committee as a stupid question, so I'm going to ask on. (laughter) Obviously, Blue Cross and Blue Shield has changed a great deal going from a non-profit to a profit, and having worked with an insurance company and knowing what a profit insurance company is, a lot of changes have occurred in Anthem Blue Cross and Blue Shield over the last few years. Is that correct?

Ms. Nanasi: It depends on how you look at it. I've been there. Been there. Done that. Was there when we were a non-profit. Was there when Anthem was a mutual and now am there, hopefully will be there, as Anthem now is a stock-held company. I would say that our corporate philosophy, in terms of how we deal with our subscribers, has not varied that much since we were Blue Cross and Blue Shield of New Hampshire. We are a still a Blue plan. We are the Blue cross licensee for New Hampshire. The difference is that because we are now a for profit company, we do conduct our business on a level that a for profit company has to in that means that I have to be very careful about what I say about company investments value because we are stock-held and we are now highly regulated industry in terms we've got the FCC and others that regulate us that we didn't before. We've very pleased that since we have become Anthem and we have the ability to tap into the resources of a large nationwide company, we are no longer unprofitable and we do make a profit.

Senator Robert B. Flanders, D. 7: Any other questions? Senator Prescott?

Senator Russell E. Prescott, D. 23: The rating that we're trying to do is also the geographic, do you see that as allowing other companies to service the North Country, to offer insurance other than where they're offering insurance now?

Ms. Nanasi: That would be really nice and I think it would be welcome for North Country. To tell you the absolute truth as an insurer, the North Country is not a profitable place to do business. It's a high cost of medical providers. It's a high cost of administration because you have a very large area and a small population base. It's very expensive to contract. It's not like Nashua or Manchester where you a plethora of providers, a couple of hospitals within five miles of each other. The North Country is a difficult place to do business. We, of course, are committed to selling insurance in the whole of the State and understand that some insurers may only want to sell regionally. That's not uncommon in other states. We will compete with them.

Senator Russell E. Prescott, D. 23: So, you see it could happen and you see as a for profit organization now that you have a commitment to service the whole State now and it could change later just like other companies?

Ms. Nanasi: We're in a very unique position and I won't belabor this because first of all, I don't believe that insurers will come into our State to insure the North Country because of the administrative costs of doing so.

Secondly, the way we are licensed for our marks as a Blue Cross plan, right now, we are the licensee for the State and so, no other Blue Cross plan could come into the State at this point in time. Those are the rules for nationwide Blue Cross plans. We all basically have to sign on the dotted line for the rules for the Blue Cross plans.

Senator Russell E. Prescott, D. 23: Thank you.

Senator Robert B. Flanders, D. 7: Any other questions? Let me announce that if anybody waiting to hear Senate Bill 174, that is going to be postponed until next week. Please make sure that everybody outside the door knows that, that are waiting. I've already sent a few home. (laughter) Fortis Health please?

Mike Kellen, Fortis Health: I'm Mike Kellen, the Chief Actuary for the Group Operations of Fortis Health in Milwaukee. We have approximately 1 million lives insured in the individual and small group markets and it's about half and half for us as far as the division. We sell primarily to groups under size 15 so we truly are in the baby group market and that gives us a good fit with the state of New Hampshire.

Recently, when you made changes to the individual market here, we re-entered as we said we would and we're here today to say if this bill passes as is, we will re-enter this market as well – the small group market as well. With it we will bring MSA's and other health reimbursement account like products. We are the national leader in the sales of the MSA's for individual products and we're very excited about them for the small group market and we'll bring those into the State should this bill pass.

A couple of quick notes. I'm going to abandon my prepared remarks and try to stay within three minutes and just make a couple of extra points. A couple of them responding to some things that were said.

First of all, I've taken a look at in our 91 NAIC model states, what proportion of the groups and individuals within those groups are better than the pool rate that you have today here in New Hampshire – the ACR pool rate – and what are above that and they're a little bit better than the numbers that occur. Approximately 70% to 75% are at or below the pool rate and then another 15% to 20% are within 10 points above it. They're close to what we've been talking about but they're slightly better.

I'd like to make a comment about adjusted community rating. Adjusted community rating works pretty well for a carrier that has a huge market share. It doesn't work well for somebody who wants to enter your market. If I were in two states, let's say, and in one state I had a 30% market share and they were both ACR states, I might argue in that state that I don't like ACR. If I had a 65% market share in the other state, I might argue that I do.

A couple of other comments. Someone mentioned the very high cost of medical underwriting. I can tell you that for Fortis Health, we spend ½ of 1% on the medical underwriting process including all of the other things you gather. So I don't know what the cost of the medical part is itself, but it's a very small part of our premium and will be that way in New Hampshire as well.

I think with that, I will open it up for questions if there's a little time for that.

Senator Robert B. Flanders, D. 7: Any questions? Senator Prescott?

Senator Russell E. Prescott, D. 23: You mentioned some insurance companies have changed the way they look at a market in terms of community rating, in Colorado where Blue Cross and Blue Shield is favor of that, do you know their market share there?

Mr. Kellen: There are five big players in Colorado, so I don't know their market share but there's – I'm going to guess that it's somewhere in the 20% to 35% range, somewhere in that range.

Senator Russell E. Prescott, D. 23: They have a 60% here.

Mr. Kellen: I don't know what it is there.

Senator Russell E. Prescott, D. 23: Thank you.

Senator Robert B. Flanders, D. 7: Any other questions for this witness? If not, thank you very much for your testimony.

Mr. Kellen: Thank you.

Senator Robert B. Flanders, D. 7: United Healthcare?

Denise Boucher, United Healthcare: Good morning, Senators. My name is Denise Boucher and I'm an employee of United Healthcare. I am here this morning representing Mr. Donald Croisetiere who's the Vice President of Small Group in the New England Region.

Unfortunately, he could not be here today due to previous scheduling but he did want me to read the following comments to the Committee this morning. ***See Attachment N.***

Senator Robert B. Flanders, D. 7: Any questions of this witness? Senator Prescott?

Senator Russell E. Prescott, D. 23: Can we have a copy of your testimony?

Ms. Boucher: Yes.

Senator Robert B. Flanders, D. 7: Any other questions?

Senator Russell E. Prescott, D. 23: I have one question. If you can't answer this that's fine.

Ms. Boucher: Okay.

Senator Russell E. Prescott, D. 23: An insurance agent testified before this Committee that rating businesses today in small groups is relatively easy. He mentioned that prior to 1994 it was harder. Can you – and if this Senate Bill 110 passed, it would then make it harder again to do rating. Would you have any idea of what he was talking about?

Ms. Boucher: I would assume that the question pertains to industry rating. Obviously, industry rating is very complex in that there are blue-collar positions or industries that there are more risk factors than white-collar industries that would be less in that perspective. So, that the industry rating was a big factor with regards to the type of industry related to that particular group that we would insure.

Senator Russell E. Prescott, D. 23: It's really the work of the underwriter not of the insurance agent?

Ms. Boucher:. That's correct.

Senator Russell E. Prescott, D. 23: Thank you.

Senator Robert B. Flanders, D. 7: Any other questions? If not, thank you for your testimony. Cindy Theberge, please? Bill Care?

Bill Carr, NH Business Council: Boy, I didn't know I changed my name but I'll take it. Good morning, Mr. Chairman, members of the Committee. My name is Bill Carr. I am the – currently, I serve as the Principal and Managing Director of the Bennington Group, which helps small businesses all over the eastern part of the United States. Plus I just recently completed my fourth term as the Chairman of the Leadership Council for the National Federation of Independent Business here in New Hampshire and currently serve as the Chairman of the Board and President of the New Hampshire Business Council, which is made up of businesses that range all the way from those that have less than 10 employees to our largest member, which has 27,000 employees worldwide.

I will be brief this morning. I have pass outs. ***See Attachment O, P and Q.*** A lot of folks have come already before me. They have – they're very professed in what they have said. They're very eloquent in how they expounded upon their comments and what I have to say is perhaps more general in nature but I think just as important.

We have to remember that not too long ago, we fought – particularly the small business community in New Hampshire fought like made to get a classification as a small business in New Hampshire to that which was anywhere from 1 to 100 employees but a maximum of 100 employees. The reasons for that at that point in time, we were being pushed out of several markets and being incorporated into large markets particularly in the area of environmental concerns, particularly in the area of capital market and unfortunately, one of the downsides

that occurs as a result of that is that you can't look in a crystal ball and see in the future that there are going to be certain aspects where being classified as a small business with anywhere from 1 to 100 employees may not be the best thing for the small business community. I think we've reached that point in this particular area of health insurance.

One of the things that we noticed and I've noticed over the years serving in the capacities that I have, is that there are two major issues in the small business community in this State: One is taxes and the second is health insurance. It's been that way ever since I can remember and I've been back here in New Hampshire now for the past 10 years. It's not unlike other states either. Most small businesses in every state consider those the top two issues you're going to run into.

We fought last year to be able to get that point across to a good number of candidates that were running for office, both for re-election and perhaps new candidates that are coming in to the mainstream of New Hampshire politics. Quite interesting to note, that we are very successful in supporting and having elected a number of candidates who saw our points of view and realized that health insurance is that critical to the small business community in this State.

We've had to deal with a large group insurance market that has fewer and fewer companies, no product choice and escalating premium cost. These are all givens so I'm not saying anything new to you all. But, what we need to do is to compare the insurance situation to buying a car. New Hampshire small businesses can only buy SUV's at the moment. A very high priced situation. We should be able to buy an economy car, a minivan or even a bicycle if that fits the needs of our company and our employees. We don't have that possibility at the moment. That's what we need. That's what SB 110 hopes to address and I believe it is addressing.

It's not a perfect piece of proposed legislation. I don't think any legislator anywhere in the Country can ever say that there is a perfect piece of legislation that's being put on the agenda. But, we have the opportunity which SB 110 to make a start. We don't know what's going to happen ten years from now. We didn't know in 1994 what was going to happen when Senate Bill 711, which at the time looked like a very good piece of "feel good" legislation; and perhaps at that time, it was. But, we have found out since that there are certain aspects of it that just don't carry the message the way it should. We're here, hopefully, today to help you make up your minds to correct that by passing out, of this Committee, SB 110, which we do think makes the difference particularly in the small business market.

I kept my remarks very brief because I did have some pass outs for you. It's much easier to read those than for me to stay here and have to take up the time because there are a lot of other people to speak but I appreciate that opportunity to at least get my remarks in and thank you. If there are any questions, I'll be happy to answer them. If there not, I'll leave and you can go to the next person.

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not, thank you very much.

Mr. Carr: Thank you.

Senator Robert B. Flanders, D. 7: I'm caught in a bind. I have two FN bills that have to be exec'd today because of the deadlines. Can we take a recess long enough for us to do those

two bills and then we'll go right back in. I don't think it will take very long. So, if I can just go take a recess for ...

Liz Murphy: Excuse me, Mr. Chairman? Angela has to catch a plane this afternoon.

Senator Robert B. Flanders, D. 7: I'm sorry. I should have asked that. Please, come up.

Angela Franklin, HIAA Trustmark: I'll be very, very brief. My name is Angela Franklin. I'm with the Health Insurance Association of America and I'm here on behalf of our members who are watching these proceedings with great interest.

I'm here to read a statement from one of our members, Trustmark, whose division is Starmark and they have operated in the small group market here, previously and they wanted to let you know that they would be interested in returning if this legislation were enacted.

This is from Ray Hasse, CEO and President of Starmark. ***See Attachment R.***

Senator Robert B. Flanders, D. 7: Any questions?

Senator Russell E. Prescott, D. 23: Yes, one question please. Does Starmark like Fortis offer medical savings accounts for the individual markets, because this Committee was concerned about those that are groups of 1 being disrupted. Do they offer that?

Ms. Franklin: I will have to check and make sure that they do get that question...

Senator Russell E. Prescott, D. 23: ... they do?

Ms. Franklin: We'll let you know.

Senator Russell E. Prescott, D. 23: Terrific. Thank you.

Senator Robert B. Flanders, D. 7: I don't dare ask if anyone else is in a hurry because everybody's going to be in a hurry. (laughter) We will recess until 11:25. Thank you.

Hearing recessed at 11:15 AM.

Senator Flanders re-opened the hearing at 11:25 AM.

Senator Robert B. Flanders, D. 7: I would like to announce that we have 8 more speakers and I would like to stop this hearing at 12:15 PM. Please keep it short so everybody will have a chance to speak. Tom Murtagh?

Tom Murtagh, Atlantic Plans: Thank you. Senators, you've heard almost all of it. So I will be brief. I think the biggest issue here is the groups of one, if there is such a thing as group of 1.

Reads from testimony handed in. ***See Attachment S and T.***

I want to review the two last pieces of paper with you. I'll do this very quick. These are actual rates, here in New Hampshire, for four group plans; two from Cigna, two from Anthem. Two individual plans from Anthem, which ... plans and two from Fortis. Fortis offers an excess of 100 different options. Two of the four choices in the high risk pool shows

you not only the cost but shows you the maximum individual out-of-pocket for these eight plans. In other words, out-of-pocket means the most an individual could pay for health services if they own these plans. In other words, catastrophic. It ranges from $2500 to $5750 on the right side.

Then there's the premium for different ages; 25, 35, 45, and 55. Then the family rates.

One the next page, you'll notice the individual rates are substantially less than the group rates. The individual market is a very price-sensitive market. The individual market services early retirees. It services people who don't have insurance because their employer doesn't offer it and services the young that come out of this pool.

The individual market, in order to be successful, has to have low cost because those people don't have the tax advantage when they buy health insurance to tax deduct the premium. (turn over tape)... these separate plans, the out-of-pocket and totals it and you'll notice we went from the Cigna Group to the Anthem Group, the Anthem Individual, the Fortis Individual and the NH Risk Pool, the premium, the out-of-pocket and the most a single person can pay in the state of New Hampshire.

I'm here to tell you that the (cough) market is a pretty good market (door closing) bills aren't that bad compared to the high rates in the group market.

The other thing is when the (cough) was set-up, it was about a year ago from now, there were no plans to look at. As far as we knew what was offered in the state of New Hampshire was $2500 deductibles or more. I'm not real happy with the four options they have. I'm lobbying them to offer a lower deductible plan and I think they're going to that when they look at it because they look at it every year. They're supposed to mimic what's going on in the private market and the rates are supposed to 25% to 50% higher that the standard rate outside in that private market.

Begins reading from ***Attachment S, bottom of page 1.***

Senator Robert B. Flanders, D. 7: Any questions of this witness? Excuse me, your testifying concern for the group of 1?

Mr. Murtagh: I agree with Senate Bill 110, totally, but the biggest concern is the group of 1 and there are options out there. That's the point. There's the individual, there's a high-risk pool and I think we've got to grandfather in those groups of 1 so they have some time to adjust to the new definition of 2 to 50.

Senator Robert B. Flanders, D. 7: Thank you for your testimony. Sean Lynch?

Sean Lynch, John Alden Health: Written testimony handed in. ***See Attachment U.***

Senator Robert B. Flanders, D. 7: Any questions?

Senator Andre Martel, D. 18: Just one quick one. Do you have (sneeze) service program under your insurance company.

Mr. Lynch: Yes.

Senator Andre Martel, D. 18: You do? Thank you.

Senator Robert B. Flanders, D. 7: That's good news. Thank you. Liz Murphy, please?

Liz Murphy, S&H/Murphy: Thank you, Mr. Chairman. I'm going to be briefer than brief because everybody has truly given the same testimony. I'm Liz Murphy. I'm here testifying on behalf of Cigna. Don Curry was not able to be here this morning.

I think there are a couple of things; Cigna currently offers an HMO product in the small group market. Our indemnity carrier, Connecticut General Life Insurance Company, withdrew the small group in 1998. As we continue to analyze whether re-entry into the small group market in New Hampshire with an indemnity product is the way we're going, any legislation bringing the New Hampshire staters closer to the traditional small group definition of 2 to 50 lives, will make that market segment far more attractive to us.

I went through some of the others things I have and everybody has testified to but I have a listing from the USGAO Office with the number of carriers, largest carrier, and market share for small group health insurance on a state-by-state basis and I think this might answer some of the questions; Colorado included. I can leave this here. ***See Attachment V.***

Senator Andre Martel, D. 18: Thank you.

Senator Robert B. Flanders, D. 7: Any questions of this witness? Thank you. Claire Hebert?

Claire Hebert: Good morning. I have redone my notes because I don't want you to hear the same things over again, but I'm here representing the sole proprietor in New Hampshire. Written testimony handed in. ***See Attachment W.***

Senator Robert B. Flanders, D. 7: Any questions? Your recommendation is 12 to what?

Ms. Hebert: 12 to 18 months is what's been proposed as a timeframe to extend the exiting 1 person groups.

Senator Robert B. Flanders, D. 7: Any other questions? If not, thank you for your testimony. Dick Stonner?

Dick Stonner Sir Speedy Printing/NFIB-NH: Thank you, Mr. Chairman, members of the Committee. I'm here today as current Chairman of the Leadership Council, NFIB, in New Hampshire and as a small business owner.

First thing, what I just passed out was a special ballot that NFIB did two weeks ago about this issue. ***See Attachment X.*** NFIB represents approximately 3,000 small businesses in New Hampshire. Of the 3,000, approximately 50% of them, 1,400 people, responded to this ballot; 75% in favor of what's before you today; 14% against and 11% undecided. I gave you this so you can see that it wasn't written to try and sway what the vote would be. I think it was very nonbiased in its writing and I wanted you to have the results.

Secondly, and I will be brief because I'm almost done with my last quarter in my meter. (laughter) We have been in business in Manchester – I'm sorry, Sir Speedy Printing Company in Manchester is our family business. We've been open 22 years. I went back, yesterday, to check our insurance bills. We're a company of 5 employees. Ten years ago we had 5 employees. We have had as many as 9.

With the technology today in printing and copying, with everything being digital and computer driven, we do much more, much better with fewer people than we used to. So this is a pretty good comparison.

In 1994 for 5 people, my monthly premium for health benefits including disability was $618.36 a month, or just over $7400 a year. This year for 5 people, it's $2389.23 per month, without the disability, for over $28,000 a year. Our coverage for 5 people has gone up approximately 400%. It's the only thing in my business that I don't have any control over because of lack of competition. I can go to my carrier and downgrade to try and save some money but I can't go – like ten years ago when my insurance man used to come in, he'd put papers from 5 or 6 or 4 different companies in front of me, each one having 3 or 4 or 5 options and we'd review it every year or two. All we do now is decide – basically, it's a done deal. This is the last year in this policy. I have an excellent policy, I don't deny that. I love the policy but we're probably over-insured in some ways. We will be changing it when the expiration date is up. I'd rather not.

In 22 years, almost every person I've hired from year to year has come to me and never had health insurance. Every one of those persons have had health insurance while they worked for us.

So, as the Chairman of NFIB and as small business owner, I'm here to encourage you to pass SB 110. I understand from testimony there will probably be some changes and some amendments but the basic route of competition is there and as a small business person, what I believe in very much. Thank you very much.

Senator Robert B. Flanders, D. 7: Any questions of this witness? Yes?

Senator Andre Martel, D. 18: You have – in your insurance plan, what is the contributory amount that your employees pay? Do they pay it all?

Mr. Stonner: We pay it all.

Senator Andre Martel, D. 18: You pay it all?

Mr. Stonner: Yes. I've been told I'm crazy to have the low deductible, high coverage that I do and pay for it. If a married employee wants to cover their dependents, they'd have to pay for that portion. But we pay for everything else including life insurance.

Senator Robert B. Flanders, D. 7: Thank you. Any other questions? If not, thank you for your testimony.

Mr. Stonner: Thank you very much, Mr. Chairman.

Senator Robert B. Flanders, D. 7: Andy Dillman?

Andy Dillman, NH High Tech Council: Written testimony handed in. ***See Attachment Y.***

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not, thank you very much. Marge McClellan?

Marge McClellan, Berlin, NH: Written testimony handed in. ***See Attachment Z.***

Senator Robert B. Flanders, D. 7: Any questions of this witness? I have – the testimony you gave was interesting, very precise. I'm just wondering where you received all of that information?

Ms. McClellan: Well, the North Country Health Consortium is mental health clinics, hospitals, home care agencies, all the social services in Coos County work together and we have a federal grant to do some research to find out and to get some statistics to see what we're dealing with. Everybody's always saying *give us statistics* and nobody wants to pay for it. So, we went to a federal grant and that's research that's done by people who know – not myself because it would take me years to figure that out. But, people who really – went after the real figures.

Senator Robert B. Flanders, D. 7: Do you have copies of that testimony?

Ms. McClellan: Absolutely.

Senator Robert B. Flanders, D. 7: Any other questions of this witness? If not, thank you for your testimony.

Ms. McClellan: Thank you.

Senator Robert B. Flanders, D. 7: Is there anyone else that wishes to speak in reference to Senate Bill 110? Yes? Your name please?

Audience: Isn't there another sheet that we all signed? (change tapes)

Mary Lucas Atwood: Written testimony handed in. ***See Attachment AA.***

Good morning. My name is Mary Lucas Atwood. I have spent over 20 years in the insurance industry working for insurers, however, this morning I am not here as an advocate for the insurance industry but really as an advocate for the small employers of New Hampshire. I left the insurance industry a couple of years ago and started my own business, so I am a small employer.

A lot of things have been said this morning, so I don't want to be redundant but a couple of points that I do want to highlight because we haven't heard from a lot of business owners or small employer groups. We heard largely from insurers and brokers today.

If you ask a small business owner if they would like to see this bill passed, if they would like to see their healthcare premiums reduced, they're going to say yes. It's as simple as that. Many of them don't really understand the overall implications of Senate Bill 110.

Begins reading from ***Attachment AA.***

The good news is New Hampshire does have a healthy population. But, New Hampshire also has a very educated population who knows how to access healthcare. The people here are high utilizers and we have excellent healthcare here. So, they access high cost, excellent healthcare which tends to keep them healthy but we don't want to take that away from them. But that is one of the drivers of the costs here.

We talk about the lack of competition among the insurers. The real issue is the lack of competition among the providers. Let me give you an example outside of the healthcare industry. One of the things that we're all facing right now is the increase in gasoline at the

pumps. I don't think that anyone here would question or argue that the cost of gasoline or that the gas station owner is the individual responsible for the increase cost in gasoline. You know, if you've got a gas station on one corner, a gas station on another corner and you put a gas station on those other two corners, it is not necessarily going to drive down the overall cost.

Begins reading from ***Attachment AA, Fallacy number 1, paragraph #2.***

He knows it's not the insurers. He knows that the drivers of the underlying costs and the premium rates lie with utilization and with lack of competition among the providers.

Begins reading from ***Attachment AA, Fallacy Number 2.***

I caught the Governor as he walking out after his testimony and made that particular point to him and he said *well, they discriminate anyway. Don't you discriminate if someone is a single employee versus somebody that has a family?* You know what? I don't! That doesn't occur to me but if I know that a dependent is going to increase the healthcare cost by 25%, you know, I don't want to know that! If you introduce medical underwriting, I may know some of those things and I don't want to know that. I don't want to feel that way about my employees.

Begins reading from ***Attachment AA, Fallacy Number 4, paragraph 2.***

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not, thank you for your testimony. Is there anyone else that wishes to speak? Yes?

Kipp Cooper, NH Association of Realtors: Thank you very much. For the record, my name is Kipp Cooper, here representing the New Hampshire Association of Realtors and our 4800 members statewide.

We are here really on a fact-finding mission today. The testimony has been very interesting. We're very supportive of the efforts of the Senate and very pleased at looking at the competition areas that exist and certainly would like to be apart of the solution as opposed to part of the problem.

One major concern that we have as a group of 4800 people is that my folks are independent contractors; they're sole proprietorships for the most part and we are very concerned with elimination of groups of 1 and what that will mean and what kind of fallout could result in the loss of coverage for those individuals.

Realtors spread the economic spectrum very widely. We have a number of entry-level people. We come in as sales people that may be only making $15,000 or $20,000 a year when they first start in the business as opposed to some of the folks that may be in the higher figures. Those people, we feel, are not going to be able to pay for their own insurance and we would hate to see the safety-net that currently exists for sole proprietors to be cut.

So, in any way that we can work with the Senate on this issue, we would like to hopefully make this a better bill to be able to provide for competition to come into the State. We also want to make sure that independent contractors and sole proprietors, as has been the case in many other states that were talked about today, are included in groups of 1 to 50 as opposed to 2 to 50. With that, I'd be happy to answer any questions.

Senator Robert B. Flanders, D. 7: Any questions of this witness? Thank you very much? You wish to speak?

Cindy Theberge: I'm on the list somewhere, I don't know what happened to it.

Senator Robert B. Flanders, D. 7: Your name?

Ms. Theberge: Cindy Theberge from Risk Management. My name is Cindy Theberge. I'm the Vice President of Risk Management. We are a broker agency representing approximately 900 employers in the state of New Hampshire. A lot of those – about half of those – are small groups under the size of 10. A lot of them are in the 10 to 50 market and a number of them are well over that.

I'm not going to take a lot of time because I agree with some of these people that spoke. I think, again, we're here not necessarily in support of or opposed to but we are saying please be careful with making sweeping changes just for the sake of change. I think we all agree that there are some changes that need to be make or that what we have right now, the costs are escalating. They are out-of-control but, again, I think it's not necessarily because we don't have competition in this State. We have a lot of users in the State that use healthcare. We have a lot of initiatives out there like the New Hampshire Healthcare Purchasing Partnership that's trying to address the cost of healthcare. We need to give those types of things some time to see what they can come up with.

I also think that we need to remember that we only put in the individual 118 in July. We need to give it some time. We need to see who's going to come back into the marketplace and see what that impact is. Groups of 1 – first of all, we have a hard time even defining who that is. Is it an employer who has two employees and only one takes the plan. Now they don't have coverage available. So, we have that issue.

We also don't have good coverage for those people. For an employer that's a sole proprietor is now all of a sudden having barely any coverage for prescription drugs, we have a huge problem.

We also need to look at the fact that over and over we were told that this is still a guaranteed issue market. That is not the case for groups over 50. It's not a guaranteed issue market. Those groups – I have groups of 100, 105 employees, 110 employees and they cannot move because nobody else wants them. So, it's not guaranteed issue. It's not that everybody else has to take them and we have to be careful with that because that word is being thrown around. Yes, it's still guaranteed issue under 50. But, under 50 we have to be really careful that these employers who are now being inundated with privacy information with HIPAA, now you're asking them to collect data. You're asking them to go out and do medical underwriting, collect that information and be aware of it (cough) and yet, be very careful that that's not used against them in a lawsuit saying *you fired me because of my daughter's claims. You fired me because of this.* Because they know that those employers have that information.

So, our recommendation would be that we keep it at 1 to 50 and give it some time. Let's see how many of these carriers that are saying they'll coming running back to the market come back. Because a lot of the carriers that left the market aren't even in the market anymore. They're not doing group health insurance any longer.

I also would say you know what, let's take a look at what Trustmark and Fortis and John Alden did pre-1994. How much of the market share did they have then when they could underwrite? I think you'll find that they had a very small market share even then.

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not, thank you. Someone else? Yes? We have 10 more minutes.

Peter Martin: Thank you. My name is Peter Martin. I'm from Newport, New Hampshire. I'm speaking on my own behalf and I'm also on the Board of New Hampshire Business Council and also on the Leadership Council for NFIB and I'm also Marketing Membership Director for the New Hampshire Business Council.

I do see there has to be some type of protection for the sole proprietor, that obviously is not in this particular bill but somewhere down the road this has to come into play.

Right now, 90% of the businesses in our State are considered small business. The difficulty is they're not here because they're working. (laughter) ...cut back a lot of time and a lot of difficulties in this market and our economy. Many of the problems that affect us are actually caused from down here in Concord and hopefully people will be able to testify more to try and turn this into a business direction rather than a political direction.

There are three up-front problems that I am observing from business people in the State and they've asked me to bring them here. I'll get to the health insurance quickly.

First is our 8.5% income tax that you call a Business Profits Tax. If you impose that on anybody else in the State, you wouldn't be here and it's a very difficult thing because people have to come up with that kind of money.

The other one is the BET tax and obviously that was supposed to temporary and it's tripled.

So, those are enormous burdens on people in business that has to be overcome before they can even afford health insurance. The difficulty is health insurance is a major cost of everything that's coming forth, high cost that you're trying to fund. You're trying to fund education; you're trying to fund these things but you need to look at the other side of the balance sheet called expenses. If you can start to lower those expense sides by something like SB 110, then that makes a bigger difference out there because the businesses in general out there that I'm talking to, they've said *nobody cares down here in Concord that we are the victims of every need to spend money.* So, somehow, the best thing I've heard today is that people are considering coming back in the market if this is passed.

Now, I don't have a problem with Anthem and I don't have a problem with Harvard. At least they're writing business in our State. Yes, they're making huge and millions of dollars. That's what business is about. You're supposed to make a profit but if you put competition in their, maybe that profit will reduce it down and somewhere somebody in the other side that's paying a premium is going to benefit from it.

Now, I can't guarantee that but at least the perception should be out there that Concord cares about competition because every time there's no competition, somehow it's for our benefit. Where?

So, it doesn't seem to work that way. So, pure and simply, I do support the bill, Senate Bill 110, but I also do feel that you need to look at also how you can help that individual, sole proprietor because there's so many of them out there and small business and business in

general run the state of New Hampshire in ways that funds but we do not want to be the victim of everything and every need of money here in Concord. Thank you very much.

Senator Robert B. Flanders, D. 7: Any questions? I assure you from my point of view this is nothing to do with politics but I would have been a lot better off if I didn't my name on this bill. (laughter) Thank you very much for your testimony. One other person? Yes?

Richard White, Clyde B Foss Agency: My name is Dick White. I was a sole proprietor as an insurance agent for 26 years. I'm now in the process of buying an agency with approximately 10 to 12 employees depending on who's retiring on any given day.

Thank you very much for the time and effort that you've put into this bill and I thank you for the time you've given us today. I do have some written testimony which I will pass on, unfortunately, not in multiple copies. ***See Attachment BB.***

I will briefly address a couple of things that I see in this bill that are problematic. I certainly will make it very clear I'm not in favor of the bill as it is currently written. The make-up of my agency if rather elderly. I am probably one of the youngest people in my agency. We have employees that are retired that we have extended healthcare coverage to. They pay the premium but we make it available for them. If you start medically underwriting me, and start effecting my cost because of the age make-up because of my group, I will have to tell you truthfully, I will probably get rid of that benefit. It may not be nice but it's a reality and I don't think I'm the only one out there like that.

I'd like to deal with sole proprietors. At best, this bill gives them three years to commit suicide. Basically, they need to change immediately to an individual health plan, otherwise they're taking a three year chance that their health will go south and they will be in the health insurance pool with higher rates and lousier coverage. I don't want to have to explain that to my clients. I can broker any company in this State but I don't like having to go to a client and telling them we just did something bad to you because there's only you as an employer.

Another thing, we talk about unexpected consequences. If we take a sole proprietor and we put him in an individual plan – in other words, he no longer can get group insurance – what do you think the odds would be that when he hires an employee, he will automatically extended that coverage to that employee? If it's a group product, it's easy; it's simple' it's a nice benefit. No paperwork, call the company and away we go. If it's an individual plan that the employer is currently insured under, what do you think the odds are he's going to take the time to call his broker, get new rates, try and figure out what's a benefit and then put that employee on the health plan? I believe it's the state's desire that we insure as many people as possible. I think you're putting a roadblock in the way of a sole proprietor when he becomes someone with employees to getting group health plan or at least thinking about doing it for those employees. Personal opinion.

I have never had a client in 26 years in the business switch from an individual plan to a group plan to get higher benefits. Maybe it's luck of the draw, I don't know. I also want to make it clear, which I didn't at the beginning, I am a Past-President of National Association of Insurance Agents and Financial whatever we are this week. We change from any of you with anything else. I'm also a member of Big I and I happen to disagree viemently with them on this bill.

I do believe we need some tweaking. I don't believe companies coming in are going to significantly reduce rates. Those rates are driven by losses which has certainly been stated

significantly better by you than me. Thank you very much (to Ms. Atwood). But, I do think the biggest flaw in this bill is that sole proprietor issue, that group of 1. You're taking someone who for 10 or 15 years has had health insurance, done what you wanted him to do – buy it before he got sick – and now what are you doing? You're throwing him out on the street. Thank you very much for your time.

Senator Robert B. Flanders, D. 7: Any questions of this witness? If not, thank you very much. That should conclude our list of speakers. Thank you very much for your patience and allowing us to go into executive session. I think that everybody's view has been heard and again, thank you very much. I will close the hearing on Senate Bill 110.

Hearing on Senate Bill 110 closed at 12:15 PM.

Respectfully submitted,

MA Chandler

Merideth Ann Chandler,
Senate Secretary
03/25/03

Attachments: 28

Attachment 9

Testimony of

Senator Russell Prescott

on SB 110

The bill before us is dealing with the reform of the group insurance market in NH. As you may know, prior to 1994, New Hampshire had very little regulation of the group health insurance market. We pretty much allowed companies to underwrite and rate as they saw fit. Most states did the same thing.

At that time, there were dozens of companies selling group health insurance in New Hampshire, and our rates were amongst the lowest in the country. Still, there were problems with that system. Some insurance companies were practicing risk avoidance rather than managing risk. Unhealthy individuals could make it difficult ~~to~~ for an entire group to obtain health insurance. Blue Cross Blue Shield claimed they were ending up with a disproportionate amount of unhealthy people since they were not underwriting their groups as other companies were.

In 1994 New Hampshire enacted adjusted community rating. At that time, this policy had virtually no track record in any other state. These laws had some positive aspects, most notably the fact that they guaranteed access to health insurance for all groups who sought it, and the new laws eliminated the market abuses that some insurance companies were practicing. At the same time, many insurers warned they could not continue doing business in our state if we became so different from an actuarial standpoint than most states. Other experts

warned that this system would drive rates upward, particularly for those under 40 years old.

Now, nine years later, having the advantage of looking backwards, we can easily see that in every state where forms of community rating have been tried, it has resulted in massive insurance company defections, spiraling rates, less choices for consumers, and the defection of some medium sized groups into self-insured plans in order to defeat this unhealthy state mandated rating system.

Insurance is not something that is good to be unique in. The fact of the matter is that it is a business based on numbers, and if other states are experiencing more success in their group health insurance markets than we are, we should look at what they are doing and try to improve on our system.

I believe that SB 110 does just that. I want to emphasize that this bill is a logical modification of the 1994 legislation. It continues to provide guaranteed access to health insurance for all groups. It utilizes the recommendations of the National Association of Insurance Commissioners' model small group law in setting appropriate limits on rating variables and rate increases. It recognizes the reality that no other state defines groups as 1 to 100. No other state. It recognizes that only 12 states have rate compression anywhere similar to ours. This bill does not take us back to 1994, but rather brings New Hampshire's insurance market laws into the present.

We are not taking away the HMO accountability act or eliminating existing mandates, but modifying rating variables to provide an incentive for insurance companies to aggressively price and market their plans: a win for small businesses. It will entice other types of plans to be offered, including medical savings account plans, preferred provider organization plans, health reimbursement accounts and indemnity plans, rather than just the HMO plans dominating our marketplace now. The fact of the matter is states with similar laws to what are being proposed here have more carriers to choose from, and more plans to choose from. With a competitive market, insurance agents and brokers and, more importantly, small businesses will have greater choice of insurance companies and insurance products.

Let me say that I have been troubled by ~~some of the misinformation and scare tactics that have been employed by~~ those opposing this bill, particulary Anthem Blue Cross and Blue Shield. ~~Anthem controls over 60% of the New Hampshire small group insurance market, the company made approximately $40 million in profit in 2001 in New Hampshire alone, and they recently stated that the companies 2002 profits were up by 60% over 2001. We should not forget that this company has a vested financial interest in preserving the status quo~~. Please do not forget that while competition and choice would be good for New Hampshire's small business community, it will be bad for Anthem.

WE NEED TO LISTEN & WORK WITH 1- PERSON CO

OVER

Governor Benson stated in his inaugural address, "don't bring me problems, bring me solutions." This Bill is Various small business people, insurance brokers and agents, the NH Department of Insurance and other insurance companies ~~have~~

~~FIRST~~ WE NEED TO LOOK AT :

STRENGTHENING THE BILL TO OFFER
SIGNIFICANT PROTECTIONS FOR
1-PERSON GROUPS
~~CONSIDER~~

AND WE NEED TO LOOK AT

ALLOWING INSURERS TO CONTINUE TO
OFFER GROUPS OF 1 WHILE MAINTAINING
~~CONSIDER~~ THE DEFINITION
OF 2-50 TO BRING US IN LINE
WITH THE MAJORITY OF OTHER STATES AND TO
~~[redacted]~~ ATTRACT INSURERS BACK
TO NH

BRINGING

~~brought~~ forward ideas and potential solutions to the issues facing our small group market. ~~At the same time, Anthem has brought forward problems~~.

I BELIEVE

The New Hampshire Legislature should encourage private sector, voluntary solutions for the ~~majority of~~ people in New Hampshire. The more businesses that voluntarily purchase health insurance for their employees, THE BETTER. ~~the fewer people that the state has to take care of in some form or fashion. We are facing budget issues that we are all clearly aware of~~. It is not in our best interest to maintain laws that continue to frustrate small businesses who want to do the right thing and purchase health insurance for their employees. We should make it as available, as flexible, and as low cost as we possibly can. We should create an environment that gives small businesses a wide variety of carriers and plan designs if possible.

The policies contained in SB 110 are not extreme or untested. These policies are based on model laws working in approximately 35 states around the country. States with ~~vibrate~~ VIBRANT, competitive markets and with product choices for small business.

Thank you for your consideration and I would appreciate your support.

Attachment B

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.

STATE OF NEW HAMPSHIRE

Inter-Department Communication

DATE January 2, 2003

FROM Veronica A. Van Loan VVL
Senior Researcher

AT (OFFICE) Legislative Services

SUBJECT Small Employer Group Sizes

TO Representative Mark Carter

You asked this office to find out how the states define "small employer" for purposes of health insurance.

29 states define group size as 2-50
(AL, AK, AZ, CA, DC, GA, ID, IL, IN, IA, KS, KY, MN, MT, NE, NV, NJ, NM, NY, NC, ND, OH, SD, TX, UT, VA, WV, WI, WY)

11 states define group size as 1-50
(CO, CT, DE, FL, HI, ME, MD, MA, SC, VT, WA)

3 states define group size as "not more than 50" (Mississippi, Oklahoma, Rhode Island)

2 states define group size as 3-25 (Missouri, Tennessee)

1 state defines group size as 2-25 (Arkansas)

1 state defines group size as 3-35 (Louisiana)

Total = 2

1 state defines group size as "less than 150" (Michigan)

1 state defines group size as 1-100 (NH)

1 state defines group size as 2-26 (OR)

I was unable to find a definition in the Pennsylvania Statutes.

Total All Others = 49

Drop this petition in the nearest mailbox.

(postage is paid)

The Health Care for New Hampshire Resolution

Whereas, New Hampshire residents pay the 12th highest cost for insurance in the country; and

Whereas, the cost of health insurance premiums for families has increased by 45% over the past three years; and

Whereas, 100,000 New Hampshire residents have no health coverage and 77% of them have a full-time worker at home; and

Whereas, due to these rising costs almost half of New Hampshire's small businesses cannot afford health coverage for their employees, therefore be it resolved

That we, the citizens of _____ [insert town], New Hampshire, call on our elected officials from all levels of government, and those seeking office, to work with consumers, businesses, and health care providers to ensure that:

- ***Everyone, including the self-employed, unemployed, un- and underinsured, and small business owners, has access to an affordable basic health plan similar to what federal employees receive;***
- ***Everyone, including employers, consumers, and the state, local and federal government makes a responsible and fair contribution to finance the health care system;***
- ***Everyone receives high quality care that is cost efficient and medically effective; and***
- ***That these efforts help control the skyrocketing cost of health care.***

Name*: _____ **Signature*:** _____

Address*: _____ **City*:** _____ **Zip*:** _____

E-mail: _____ **Phone: (603)** _____ **Date*:** _____

☐ ***Yes! I want to help collect signatures to get this resolution on the agenda. Please send me an additional 10 postcards.***

Name*: _____ **Signature*:** _____

Address*: _____ **City*:** _____ **Zip*:** _____

E-mail: _____ **Phone: (603)** _____ **Date*:** _____

☐ ***Yes! I want to help collect signatures to get this resolution on the agenda. Please send me an additional 10 postcards.***

*** Required Information***

Attachment C

Rep. Carter, Hills. 44
February 3, 2003
2003-0142h
01/09

Amendment to SB 110

Amend the bill by inserting after section 9 the following and renumbering the original section 10 to read as 11, respectively:

10 Insurance; Loss Information. Amend RSA 420-G:12-a to read as follows:

420-G:12-a Loss Information Provided to [~~Large~~] Employers.

I. Upon written request, every health carrier shall provide loss information concerning a [~~large employer~~] policy or contract at least once every 6 months from the date the policy becomes effective.

II. If a policyholder requests loss information from an insurance agent or other authorized representative, the representative or agent shall transmit the request for loss information to the health carrier within 4 working days.

2003-0142h

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 requires loss information to be provided to all employers. Current law requires such information to be provided to large employers only.

Attachment D

Representative Mark Carter
Testimony on Amendment 0142h to SB110
(Small Growth Health Insurance Reform)
(03/18/03)

- Very Simple, straightforward, sensible amendment to existing law.
- **All employers shall be provided their Loss Information upon request.**
- Knowledge is power - this info. rightfully belongs to the policy holder- it is the policyholder's claims history.
- The policy holder may then compare premiums paid vs. claims costs paid and make informed decisions (such as):
  - They are satisfied with their existing health insurance contract.
  - They will consider bids from other providers.
  - They will consider "self insuring", and better understand their risk/ return equation".
  - They will consider MSA's (Med. Savings Account).
- In any case the information allows for informed choices and downward pressure on insurance premiums.
- Will the community rated small group premiums tend to go up as some "good risk" insured's opt out for self-insurance/MSA's? Undoubtedly- but should small group employers be trapped into unreasonably high premiums by a monopoly on claims cost information? Definitely Not!
- A stable rate structure will ultimately be struck that will more fairly represent the actual experience and risk preference of any / all who remain within the 2-50 small group category.

Attachment E

Fact Sheet

New Hampshire's Insurance Markets: The Individual Market, the Small Group Market, and the Large Group Market

- New Hampshire has three insurance markets; the individual market, the small group market, and the large group market.

- Each market is governed by different market rules. The individual market is experience rated without guaranteed issue or guaranteed renewal. The small group market is community rated and has both guaranteed issue and guaranteed renewal. The large group market is experience rated and does not have either guaranteed issue or guaranteed renewal.

- Employers also provide coverage for health care costs through self-insured employee benefit plans. New Hampshire does not regulate self-insured employee benefit plans. Approximately 325,000 people receive coverage for health care costs through New Hampshire based self-insured employee benefit plans.

- Approximately 700,000 people receive coverage for health care costs through New Hampshire insurance policies or self-insured employee benefit plans. Of these, approximately 550,000 reside in New Hampshire. Slightly over half of the 700,000 covered persons obtain their coverage in either the small group or large group market, 17,000 have individual coverage, and slightly less than half are covered under a self-funded employee benefit plan.

The Group Markets

- Employer based group insurance plays a large role in the provision of health insurance to New Hampshire adults. New Hampshire's rate of employer based insurance coverage substantially exceeds the national average. Nearly 90 percent of non-elderly insured adults obtain their coverage through employer based coverage compared with 76 percent nationally.

- New Hampshire allows self-employed individuals (groups of one) to obtain insurance coverage in the small group market. Carriers that offer coverage to self-employed individuals in the small group market may restrict the enrollment to two designated open enrollment periods.

- Almost 75 percent of the businesses in New Hampshire have fewer than 10 employees. Generally, smaller firms and those involved in retail are less likely to offer health insurance to their employees. These firms also tend to have higher

employee cost sharing than large firms and those engaged in manufacturing and construction.

- Approximately, sixty percent of the covered employees in the small group market work for businesses with 25 or fewer employees. Thirty-five percent of the employees in the small group market work for businesses with 9 or fewer employees, and approximately 17 percent work for businesses with more than 50 employees.

- The average per member per month premium in the small group market is substantially the same as the per member per month premium in the large group market.

The Individual Market

- The individual market is the smallest market segment with slightly more than 17, 000 covered lives.

- Individual health insurance tends to have higher deductibles than group insurance and less comprehensive benefits.

- In 2001, legislation was passed reforming the market rules in the individual market and creating the high risk pool. The legislation repealed guaranteed issue and guaranteed renewal and allowed health status underwriting. Since then, one carrier has entered the market and one carrier has exited the market.

- Individual insurance in New Hampshire is not guaranteed issue or guaranteed renewal. A health carrier may refuse to issue an individual policy based on a person's health status.

- Any New Hampshire resident who is turned down by a carrier may obtain individual insurance in the high risk pool. Individual insurance in the high risk pool has guaranteed issue and guaranteed renewal.

The Uninsured

- In 2001, approximately 8.3 percent of New Hampshire's non-elderly population did not have health insurance. This breaks down as follows: 5.1 percent of persons under age 19 lacked health insurance, and approximately 9.5 percent of persons between the ages of 19-64 lacked health insurance. Nearly one of every ten non-elderly adults in New Hampshire are uninsured compared to one out of twenty children.

- Approximately 23 percent of persons with incomes below 185% of the federal poverty level do not have health insurance compared with 3 percent of persons with incomes over 400% of the federal poverty level.

- Nearly three-quarters of all uninsured adults in New Hampshire are employed. Of those, nearly 80 percent work 30 or more hours a week.

- Approximately 70 percent of the uninsured are employed by firms having between 10-100 employees, while nearly 30 percent are either self-employed or work for an employer with fewer than 10 employees.

- Of the uninsured working adults, 32.3 percent are offered insurance, but decline coverage, 25.6 percent work at a business that offers insurance but are ineligible for coverage, and 42.2 percent work for an employer that does not offer coverage.

Market Share

- Anthem presently holds approximately a 59% market share in the small group market. Cigna holds a 26% market share, followed by Aetna with a 9% market share, and Harvard with a 5% market share.

- The two largest carriers, Anthem and Cigna, insure approximately 75% of the lives in the small group market.

- The number of carriers participating New Hampshire's insurance market has declined since 1994. Since 1994, the number of carriers participating in the individual market has dropped from 6 to 4, and in the group market from 26 to 9.

- The market share of the two largest carriers, Cigna and Anthem, has increased from 60% in 1997 to 82% in 2001.

- Approximately 182,000 people obtain coverage in the small group market compared with 338,000 people in the large group market. A higher percentage of people in the small group market obtain coverage through a fully insured product than through self-insurance. Nearly a third of those who obtain coverage in the large group market are self-insured with stop loss protection.

Premium Costs

- The premium costs in the small and large group markets are similar.

- The price of a comparable insurance product is generally higher in the individual market than in the group market due in part to higher administrative costs.

- Premium costs are difficult to compare among different markets and different states because insurance products differ. Differences in product design and benefits may affect the premiums.

- Compared with the rest of the nation, premiums for insurance coverage in New Hampshire group markets are unremarkable. As shown in a national study performed by Kaiser Family Foundation, the premium costs across most states are tightly clustered, ranging from about $200.00 a month to $225.00. Small differences in premium may result in a substantial difference in ranking. New Hampshire's premiums as reported by Kaiser fall at the high end of this tightly clustered range.

Average Premium Costs for New Hampshire Group Insurance for the year 2000

- According to the 2000 New Hampshire Statutory Filings, the average per member per month cost of group insurance was $192.97, resulting in an estimated average per employee per month cost for 2000 of $210.33. This cost estimate includes both the small and large group markets.

- According to a national study performed by Kaiser, the national average per employee per month cost for group insurance for the year 2000 was $221.22. Kaiser estimated the average per employee per month cost in New Hampshire at $232.53.

- Based on information obtained from the 2000 New Hampshire Statutory Filings, the estimated average per employee per month premium cost of $210.33 in New Hampshire is below the national average cost of $221.00 per employee per month reported by the Kaiser Family Foundation.

Average Premium Costs for New Hampshire Group Insurance for the year 2001

- As reported in New Hampshire's Supplemental Report for 2001, the average per member per month cost of group insurance, including the small and large group markets, was $181.39 per member per month. The estimated per employee per month cost is $197.71.

- As reported in the 2001 New Hampshire Statutory Filings, the average per member per month cost of group insurance, including the small and large group markets, was $223.96. This results in an estimated per employee per month cost of $244.12.

Average Premium Costs for New Hampshire Group Insurance for the year 2002

- According to the 2002 New Hampshire Statutory Filings, the average cost per member per month for group insurance in New Hampshire ranges from $246.78 in the first quarter to $249.99 in the third quarter. This results in an estimated cost per employee per month that ranges from $269.00 to $272.49.

- The Kaiser study reports a national average per employee per month cost of $255.00 for the year 2002.

Comparison in Premium Costs for New Hampshire Small Group and Large Group Markets

- According to New Hampshire's 2001 Supplemental Report, the average per member per month cost for group insurance in the large group market for the year 2000 was approximately two dollars less than the average per member per month premium cost in the small group market.

- The small group market in New Hampshire has modified community rating, with rate adjustments for age and the size of the group. The rates in the large group market are determined based on the experience of the group.

Employment Based Insurance

- Most businesses in New Hampshire offer health insurance to their employees.

- Almost 95 percent of persons employed in New Hampshire work for a firm that offers health insurance.

- The likelihood that an employer will offer insurance increases as the size of the business increases. Most, if not all firms of 50 or more employees offer health insurance, compared with an offer rate of 88 percent for firms having between 10-49 employees, and 56 percent of firms with 2-9 employees.

- Coos, Grafton, Sullivan, and Strafford Counties have the lowest percentage of firms offering health insurance, while Strafford county has the highest percentage of employees that are offered health insurance.

- Over 85 percent of those who are offered health insurance by their employer take it.

- Over half of the employers that do not offer coverage would never start offering coverage regardless of a decrease in price.

- Over half of the employers that offer insurance would never stop offering coverage regardless of an increase in price.

Findings from the Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, 2001

- Health Insurance Offer Rates for New Hampshire Employers (By Firms)
  - 71.2 percent of employers offer insurance
  - 28.8 percent of employers do not offer insurance

- Percentage of Employees at New Hampshire Firms that Offer Health Insurance (By Employee)
  - 94.3 percent work for an employer that offers insurance
  - 5.7 percent do not work for an employer that offers insurance

- Health Insurance Offer Rates for New Hampshire Employers by Firm Size* (2001)
  - 1 Employee — 88.8 percent offer insurance
  - 2-9 Employees — 56.8 percent offer insurance
  - 11-50 Employees — 89.3 percent offer insurance
  - 51-99 Employees — 100.0 percent offer insurance
  - 100+ Employees — 100.0 percent offer insurance

  ***By comparison,** a national study conducted by the Center for Disease Control in 1993 estimated the offer rates in New Hampshire by firm size as follows:

  - Fewer than 10 employees — 44.7 percent offered insurance
  - 10-24 employees — 66.4 percent offered insurance
  - 25-99 employees — 96.4 percent offered insurance
  - 100 or more — 99.9 percent offered insurance
  - Fewer than 64 — .3 percent offered insurance
  - More than 50 employees — 99.9 percent offered insurance
  - Overall — 84.7 percent offered insurance

- Health Insurance Offer Rates by Industry Sector (By Firms)
  - Agriculture — 76.4 percent offer insurance
  - Construction — 69.4 percent offer insurance
  - Manufacturing — 78.4 percent offer insurance
  - Transportation — 64.3 percent offer insurance
  - Wholesale — 74.5 percent offer insurance
  - Retail Trade — 60.8 percent offer insurance
  - Financial Services — 85.3 percent offer insurance
  - Business Services — 73.8 percent offer insurance
  - Professional Services — 80.5 percent offer insurance
  - Healthcare — 82.8 percent offer insurance
  - Childcare — 100.0 percent offer insurance

  Note: These percentages are based on small sample sizes.

- Health Insurance Offer Rates by County (By Firms)
  - Belknap County — 70.9 percent of the employers offer health insurance
  - Carroll County — 76.3 percent of the employers offer health insurance
  - Cheshire — 73.6 percent of the employers offer health insurance

- Coos — 48.6 percent of the employers offer health insurance
- Grafton — 60.2 percent of the employers offer health insurance
- Hillsborough — 78.3 percent of the employers offer health insurance
- Merrimack — 74.8 percent of the employers offer health insurance
- Rockingham — 70.9 percent of the employers offer health insurance
- Strafford — 66.7 percent of the employers offer health insurance
- Sullivan — 63.3 percent of the employers offer health insurance

- Percentage of Employees at New Hampshire Firms that Are Offered Health Insurance By County
  - Belknap County — 93.1 percent of the employers offer health insurance
  - Carroll County — 93.4 percent of the employers offer health insurance
  - Cheshire — 91.9 percent of the employers offer health insurance
  - Coos — 93.7 percent of the employers offer health insurance
  - Grafton — 90.6 percent of the employers offer health insurance
  - Hillsborough — 96.7 percent of the employers offer health insurance
  - Merrimack — 93.9 percent of the employers offer health insurance
  - Rockingham — 90.1 percent of the employers offer health insurance
  - Strafford — 97.9 percent of the employers offer health insurance
  - Sullivan — 90.9 percent of the employers offer health insurance

- Monthly Premium for Individual Health Insurance Policy (By Firms)
  - $110-184 per month — 24.5 percent of employers
  - $185-224 per month — 24.1 percent of employers
  - $225-289 per month — 24.8 percent of employers
  - $290-485 per month — 26.7 percent of employers

- Monthly Premium for Family Health Insurance Policy (By Firms)
  - $215-399 per month — 21.3 percent of employers
  - $400-559 per month — 25.7 percent of employers
  - $560-734 per month — 24.4 percent of employers
  - $735-1300 per month — 28.7 percent of employers

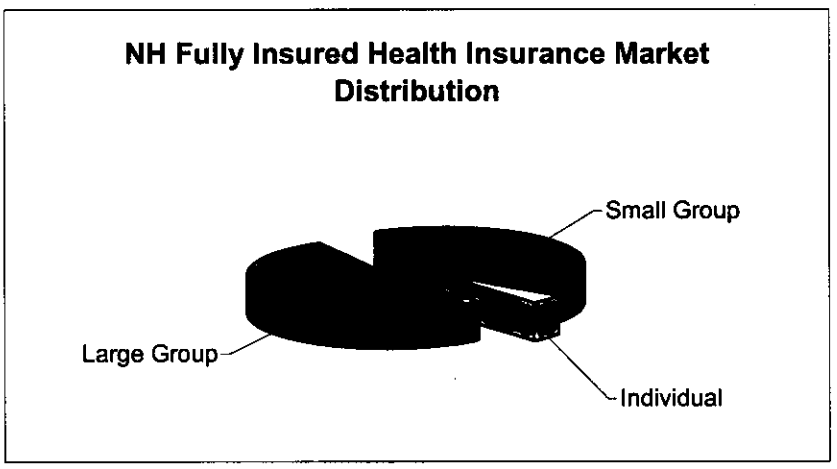
- Eligible Employees at New Hampshire Firms Who Take Coverage (By Employee)
  - 86.05 percent of all employees who are offered coverage take coverage.

- Percentage Decrease in the Cost of Health Insurance that Would Cause New Hampshire Employers that Do Not Offer Coverage to Start Offering Coverage
  - 54.1 percent of employers that do not offer coverage would never start offering coverage regardless of the percentage decrease.
  - 21.2 percent of employers would start offering coverage if the cost of health insurance decreased by 50 percent.
  - 1 percent of employers would start offering coverage if the cost of health insurance decreased by 10 percent.

- Percentage Increase in the Cost of Health Insurance that Would Cause New Hampshire Employers that Offer Coverage to Discontinue Coverage

- An increase of 1 to 9% would not cause any employers to discontinue coverage.
- An increase of 10-25% would cause 24.6 percent of employers to discontinue coverage.
- An increase of 26-55% would cause 25.3 percent of employers to discontinue coverage.
- 50.1 percent of employers would not discontinue coverage regardless of an increase in premiums.

Attachment F

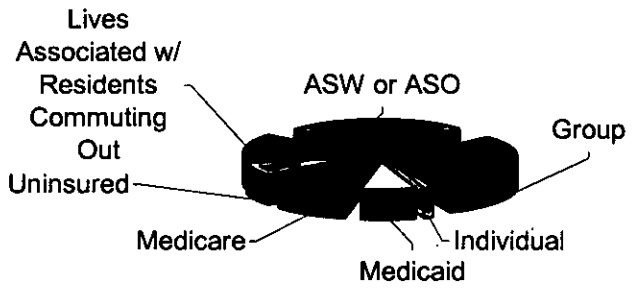


Large Group	224,138	53%
Small Group	181,733	43%
Individual	17,362	4%

Source: NH DOI Supplemental Reports, 2001

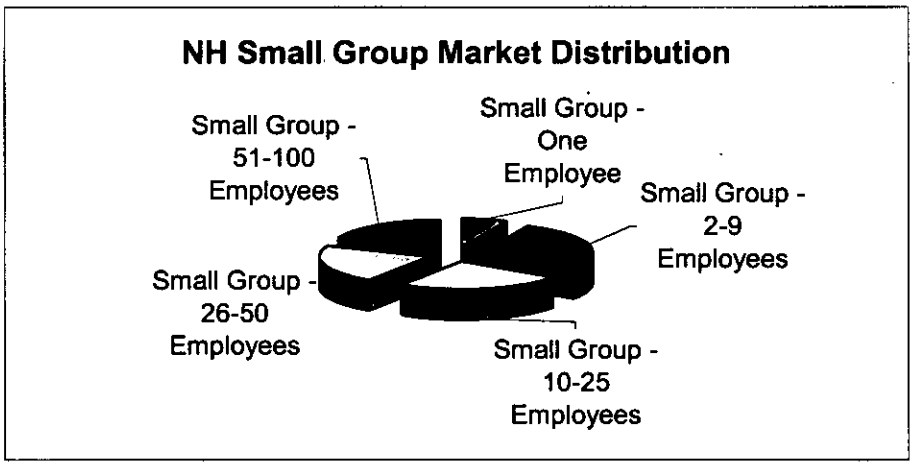
NH Insurance Department, February 24, 2003

Estimated Distribution of Coverage



	Lives (000)	%
ASW or ASO	324	27%
Group	367	31%
Individual	17	1%
Medicaid	95	8%
Medicare	137	11%
Uninsured	90	8%
Lives Associated w/ Residents Commuting Out	170	14%

Source Notes:
Lives Associated with Residents Commuting Out of State based on NH Commuting Patterns, http://www.nhes.state.nh.us/elmi/commpatt.htm
Medicaid Covered LIves - DHHS, Christina Purdum
Uninsured Lives - HRSA Interim Report, March 2002
Individual Lives - NHIHPBA Assessment Reports, 2001
Group Lives - DOI Supplemental Reports, 2001 adjusted for Nonresidents Commuting In

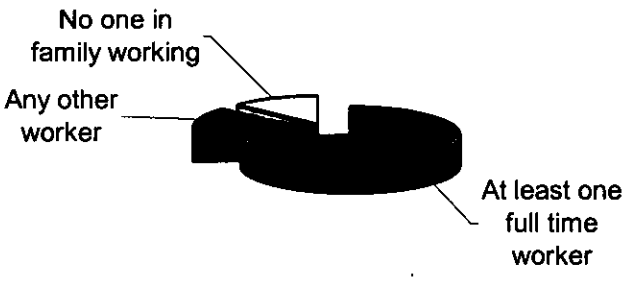


Small Group - One Employee	12,279	7%
Small Group - 2-9 Employees	50,338	28%
Small Group - 10-25 Employees	45,133	25%
Small Group - 26-50 Employees	39,445	22%
Small Group - 51-100 Employees	34,538	19%

Source: DOI Supplemental Reports, 2001

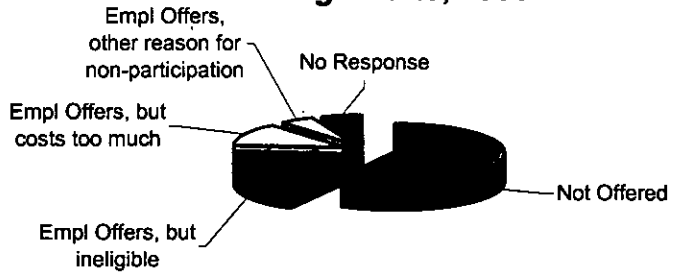
NH Insurance Department, February 24, 2003

The Currently Uninsured by Family's Work Status, 1999



At least one full time worker	73%	70,080
Any other worker	14%	13,440
No one in family working	13%	12,480

Offer of, and Participation in, Employer Based Insurance for Currently Uninsured Working Adults, 1999

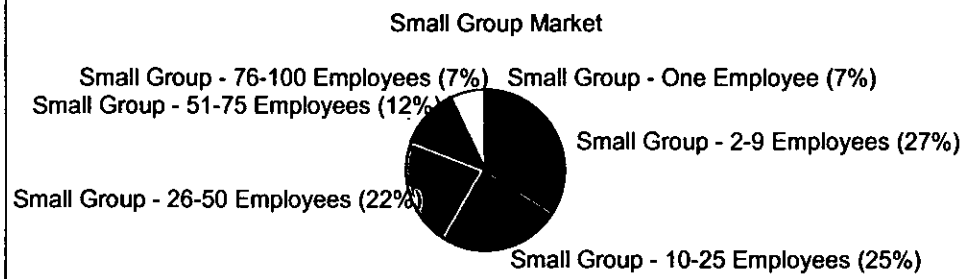


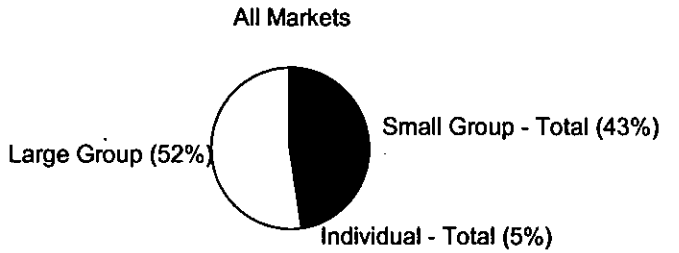
Not Offered	58%	48,442
Empl Offers, but ineligible	18%	15,034
Empl Offers, but costs too much	13%	10,858
Empl Offers, other reason for non-participation	5%	4,176
No Response	6%	5,011

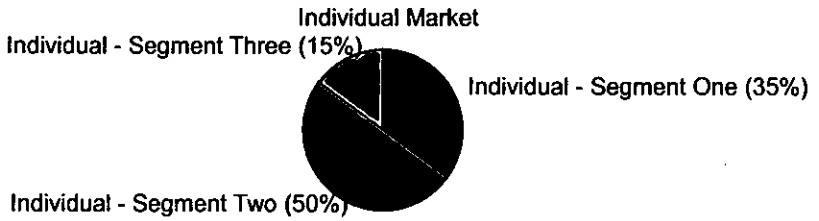
Source: DHHS Report "Health Insurance Coverage and the Uninsured in NH", http://www.dhhs.state.nh.us/DHHS/HPR/LIBRARY/Program+Report/B3.htm

Distribution of Covered Lives by Market

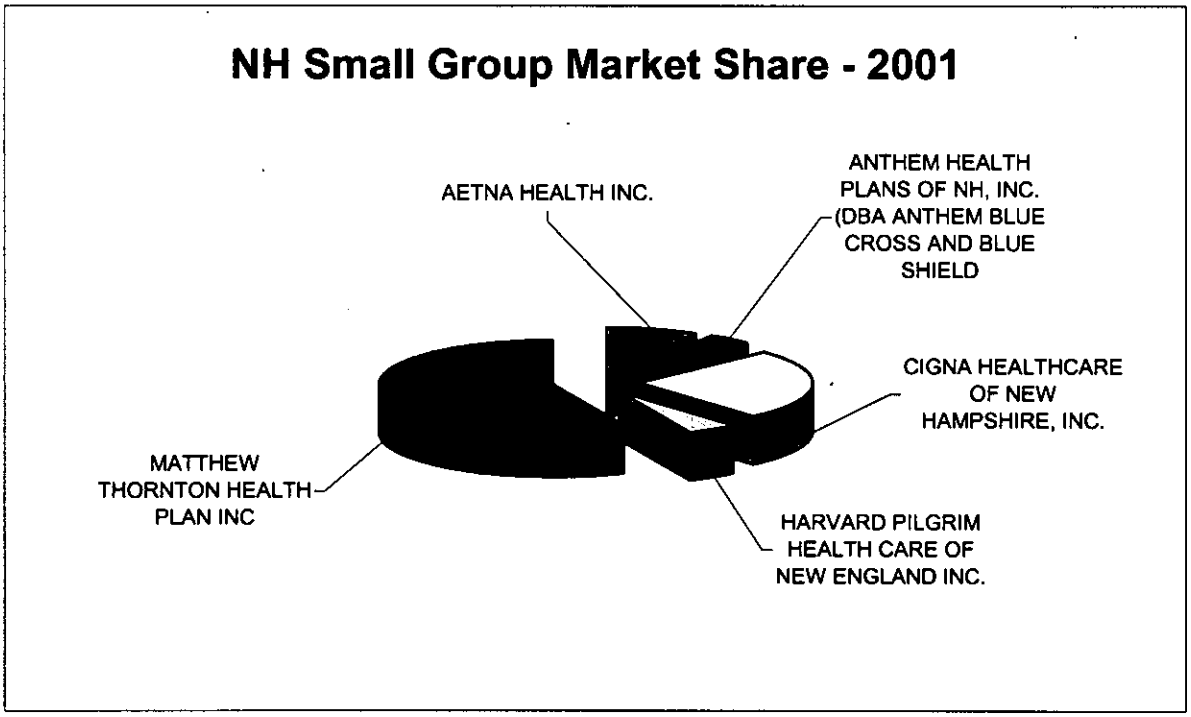
(New Hampshire 2001 Supplemental Reports)







Market Share	Small Group Market	Individual Market	All Markets
Small Group - One Employee	12,000		
Small Group - 2-9 Employees	50,000		
Small Group - 10-25 Employees	45,000		
Small Group - 26-50 Employees	41,000		
Small Group - 51-75 Employees	22,000		
Small Group - 76-100 Employees	13,000		
Small Group - Total			183,000
Individual - Segment One		7,000	
Individual - Segment Two		10,000	
Individual - Segment Three		3,000	
Individual - Total			20,000
Large Group			224,000



Company	Covered Lives	Market Share
AETNA HEALTH INC.	15746	9%
ANTHEM HEALTH PLANS OF NH, INC. (DBA ANTHEM BLUE CROSS AND BLUE SHIELD	7418	4%
CIGNA HEALTHCARE OF NEW HAMPSHIRE, INC.	47320	26%
HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND INC.	8628	5%
MATTHEW THORNTON HEALTH PLAN INC	103019	57%

Source: NH DOI Supplemental Reports

March 12, 2003

Number of Carriers Participating in Certain NH Insurance Markets by Calendar Year

	Individual Market	Small Group Market
1994	6	26
1995	5	28
1996	5	24
1997	5	24
1998	3	19
1999	3	15
2000	3	12
2001	2	9
2002	4	9

NH Insurance Department, February 24, 2003

Market Share of the Two Largest Carriers

	STAT 1997	STAT 1998	STAT 1999	STAT 2000	STAT 2001
CIGNA	28%	33%	36%	34%	31%
BCBS and affiliates	31%	27%	30%	47%	50%
Total of Two Largest Carriers	60%	60%	65%	81%	82%

Source: DOI Statutory Annual Statements

NH Insurance Department, February 24, 2003

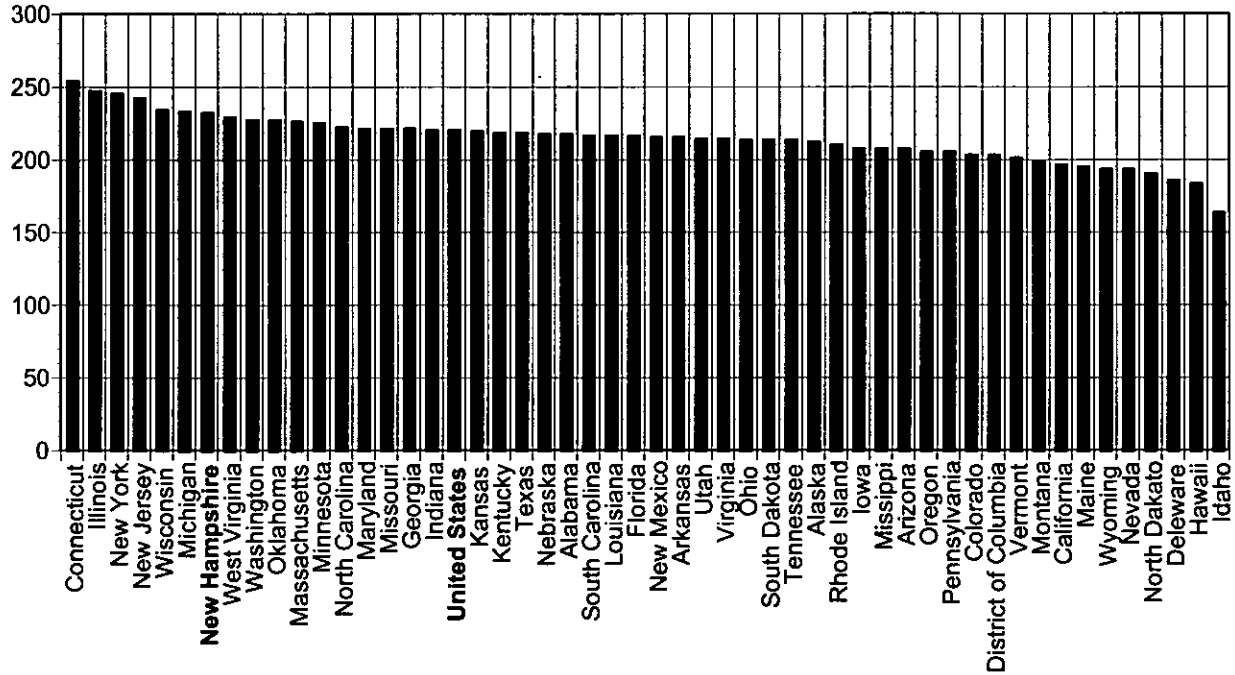
Trend in NH Revenue PMPM

	STAT 1999	STAT 2000	STAT 2001
Trend	**6.5%**	**32.1%**	**16.1%**

Source: DOI Statutory Annual Statements

NH Insurance Department, February 24, 2003

Health Insurance Cost for Single Employee Coverage



Source: Kaiser Family Foundation State Health Facts, 2000

Notes: Figures may not sum exactly due to rounding

For the United States as a whole, the margin of error for annual single premium estimates is approximately $9.50. In most states, the margin of error on annual single premiums ranges between $50-100.

For worker contributions estimates in the Untied States as a whole, the margin of error for family premiums is approximately $6.50. For most states, the margin of error on family premiums ranges between $20-60.

For the United States as a whole, the margin of error on the annual percent of worker contributions for single premiums is approximately 0.26%. For most states, the margin of error on the annual percent of worker contributions for single premiums ranges between 0.6-3.0%.

Footnotes:

1. MEPS surveys the 20 least populous states (and the District of Columbia) on a rotating basis. The most recent information for these states was collected in 1997. In 1997, the average cost of single coverage in the US as a whole was $2,050.82. The average worker contribution was $319.99.

2. MEPS surveys the 20 least populous states (and the District of Columbia) on a rotating basis. The most recent information for these states was collected in 1998. In 1998, the average cost of single coverage in the US as a whole was $2,174.35. The average worker contribution was $383.48.

3. MEPS surveys the 20 least populous states (and the District of Columbia) on a rotating basis. The most recent information for these states was collected in 1999. In 1999, the average cost of single coverage in the US as a whole was $2,324.76. The average worker contribution was $420.35.

***Note:**

The discrepancy reported for New Hampsrhie substantially exceeds the reported margin of error. The estimated average per employee per month cost in New Hampshire was $210.33 based on the New Hampshire 2000 Statutory Filings. This produces a difference of almost $250.00 on an annual basis.

Attachment G

New Hampshire Insurance Department
March 17, 2003

SB 110: Analysis

A. Current small group market rules:

1. Small groups are defined as groups with 1-100 members.

2. Small groups may be rated up or down from the average or community rate based on the age of the members. The maximum permissible variation allowed under the age rating factor is 3 to 1—that is, the rate for the highest rated group based on age of members can be no more than 3 times the rate of the lowest rated group.

3. Small groups may be rated up or down from the average or community rate based on the size of the group with a maximum permissible variation of 20% or 1.2 to 1.

4. The following consumer protections are in place: guaranteed issue[1], guaranteed renewability[2], portability[3], and limitations on preexisting condition exclusion periods.[4] In addition, the Insurance Department reviews rate filings and conducts market conduct examinations to assure compliance with numerous statutory and regulatory standards.

B. Changes to the small group market rules contained in SB 110:

1. Changes the definition of small group from 1-100 to 2-50.

2. Changes the small group rating factor for age from 3 to 1 to 4 to 1.

3. Introduces a small group rating factor for geographic location of 15%.

4. Introduces a small group rating factor for industry classification of 20%.

5. Introduces a small group rating factor for health status of +/-25%.

---

[1] No group may be denied insurance from any insurer selling in the small group market, and all products must be actively marketed to all groups.
[2] Once a health policy is purchased, the insurer is generally required to renew the policy at the option of the insured.
[3] Anyone with a preexisting condition who changes employers and therefore insurers shall have his or her period of coverage with the previous carrier applied as a credit against the succeeding insurer's preexisting condition exclusion period.
[4] Benefits must be provided for all preexisting conditions for an insured whose policy has been in effect for at least 9 months. A lesser exclusion period applies for insureds who have been without treatment or expense for a preexisting condition for a period of 3 consecutive months beginning on or after the effective date of the policy.

6. Limits premium increases that small groups will experience at renewal in the following two ways:

   a. The increase that is solely attributable to changes in the health status factor is limited to 15%.

   b. During a transition period that ends January 1, 2005, the increase that is solely attributable to the combined effect of changes in the rating factors for health status, geographic location, and industry classification is limited to 25%.

7. There are no changes in SB 110 to the requirements of guaranteed issue, guaranteed renewability, portability, and limits on preexisting condition exclusion periods. Nor is there any change to the Insurance Department's obligation to review rate filings and conduct market conduct examinations to assure compliance with statutory and regulatory requirements.

C. Effects of generally easing the rating restrictions and narrowing the definition of the small group market:

1. Easing the rating restrictions will increase the incentive for an insurer to enter the New Hampshire small group market if the insurer places a high priority on underwriting flexibility. New insurers entering the market in response to this change may not be in a position to garner a large share of the market.

2. More product choices may become available. This, in turn, may increase competition based on product design.

3. Rates for some groups will be lower than they would be under the current market rules. These groups will then be more likely to maintain current levels of coverage or possibly increase coverage. On the other hand, rates for some other groups will be higher than they would be under the current market rules. These groups will then be more likely to reduce their level of coverage (for example, through higher deductible, copayment or coinsurance requirements) or to drop coverage—a phenomenon that is occurring with increasing frequently in the current market as groups respond to large premium increases.

4. Some healthier, lower cost groups may come into the insured market, either from the ranks of the uninsured or from the self-funded or self-insured population.

5. The additional rating flexibility provided in this bill might protect New Hampshire's small group market from having many of its best risks drained off if federal law is enacted creating an option for Association Health Plans.

6. The introduction of geographic rating and the narrowing of the definition of a small group may increase the chances that existing insurers with statewide provider networks remain statewide and do not withdraw from the north country

or the seacoast—the higher cost regions of the state.

7. Due to the variable impact over time of health status on a group's risk profile, some groups may experience greater year-to-year rate volatility, independent of trend.

8. Insurers may place a decreased emphasis on competing on the basis of efficiency and risk management and an increased emphasis on competing on the basis of risk selection.

9. The changes to the definition of a small group may have a negative impact on some of the groups that eventually will be excluded from the small group market—that is, some of the groups of one and some of the groups of 51 to 100.

10. The immediate effect of these changes will be to redistribute insurance costs between the various insured groups without directly affecting medical claims costs.

D. Effects of changing the definition of the small group market from 1-100 to 2-50:

1. New Hampshire's definition of the small group market will be consistent with many other states and with the definition of the small group market in the federal Health Insurance Portability and Accountability Act (HIPAA).

2. It may protect the small group market from the adverse selection that occurs when groups of 51-100 self-insure during periods of favorable claims experience and fully insure when their claims experience worsens.

3. It may have a negative impact on choice, price, or amount of coverage for some of the self-employed when those persons no longer have access to the small group market.

4. It may have a negative impact on price or amount of coverage for some groups of 51 to 100 when those groups are excluded from the small group market.

E. Effects of changing the rating factor for age from 3 to 1 to 4 to 1:

1. It will allow insurers to more accurately rate groups based on the demographic composition of the group.

2. It will tend to lower premiums for groups with predominantly younger members and increase premiums for groups with predominantly older members.

F. Effects of introducing a rating factor for geographic location of 15%:

1. It will allow insurers to reflect geographic differences in cost in the prices they quote in different regions of the state.

2. It may encourage employers and covered persons located in the region of high-cost providers to put pressure on such providers to control costs.

3. It is likely to cause rates to go up in the north country and in the seacoast.

G. Effects of introducing a rating factor for industry classification of 20%:

1. It will allow insurers to more accurately rate groups based on the risk associated with industry type.

2. It will tend to lower rates for low risk industries and raise rates for high risk industries.

H. Effects of introducing a rating factor for health status of +/-25%:

1. It will allow insurers to more accurately rate groups based on health status.

2. It will tend to lower premiums for healthier groups and raise premiums for groups whose members are less healthy.

3. Employers who are rated up due to health status may be encouraged to promote wellness and disease management programs.

I. Effects of the caps on premium increases:

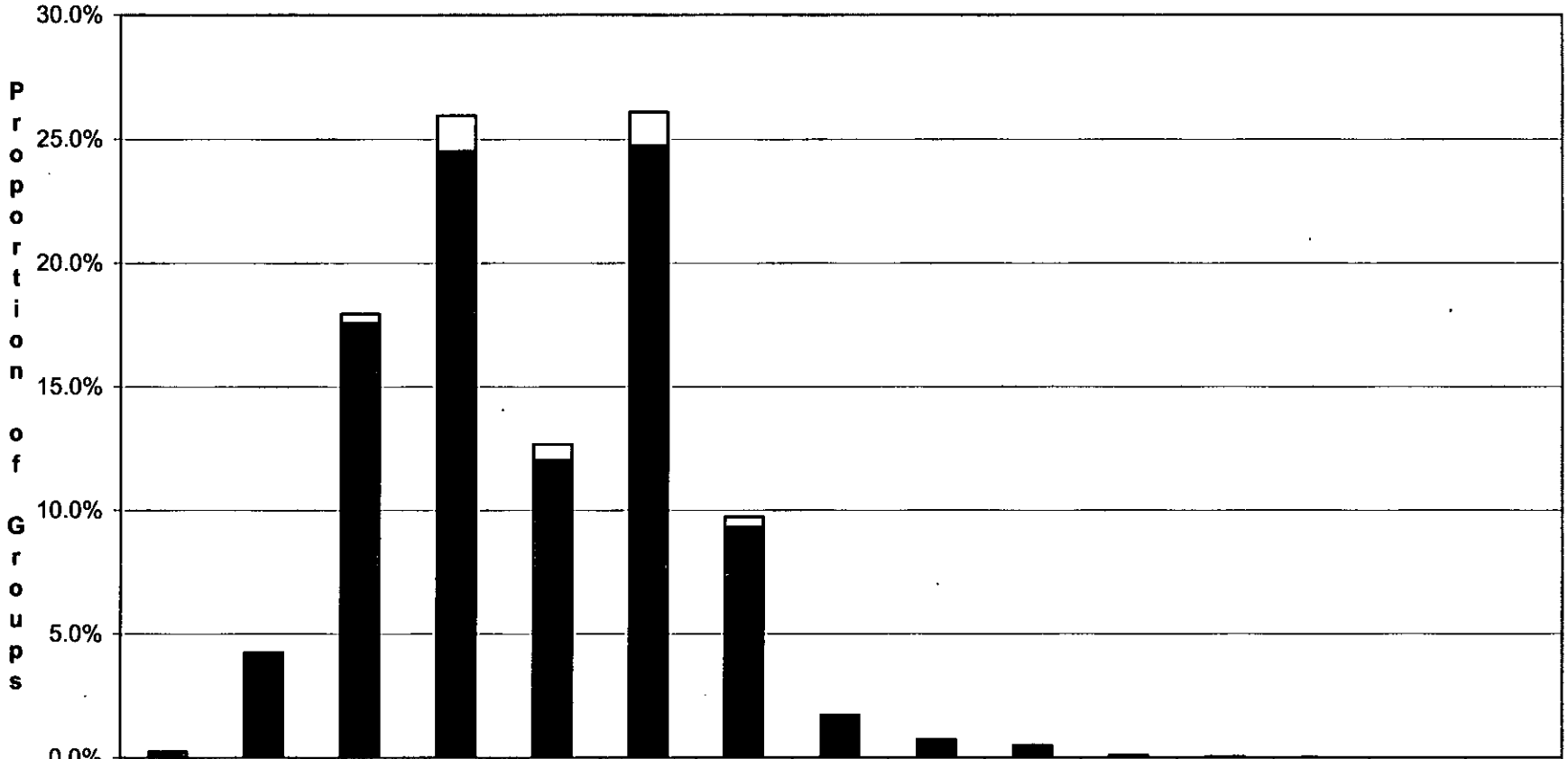
1. The caps will reduce the amount of the year-to-year premium increase that any one group can experience.

2. Caps are easier to administer than a high-risk pool or a reinsurance pool.

3. The caps do not apply to all the factors affecting premium rates or to trend. Therefore, some groups are likely to experience increases at renewal that are larger than 25%.

4. The caps do not protect higher risk groups from the cumulative effect of higher than average premium increases over a period of years.

Impact of Small Group Reform on Current Rates

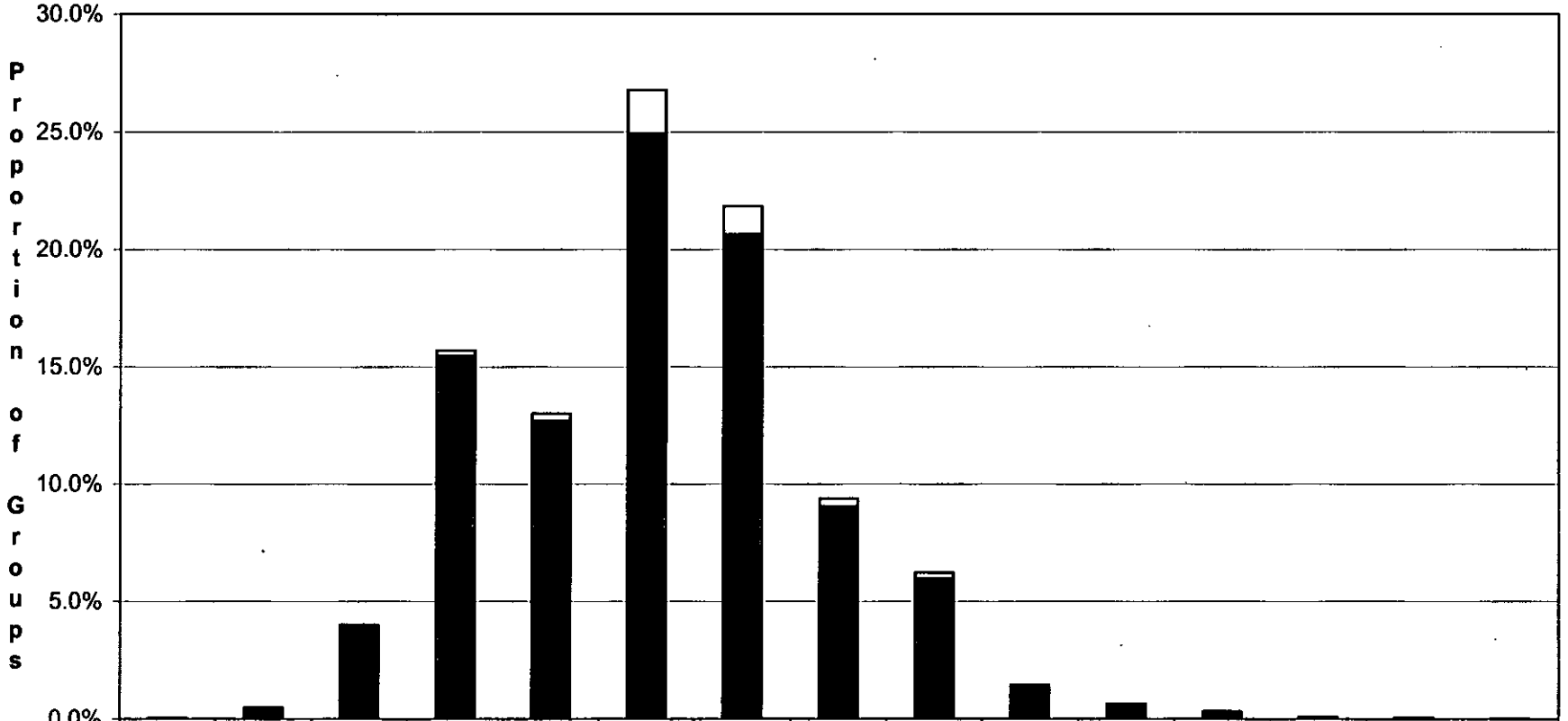


	-40%	-30%	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
□25-50	0.0%	0.0%	0.4%	1.4%	0.6%	1.4%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0
■10-24	0.0%	0.2%	1.9%	4.9%	2.4%	5.2%	1.8%	0.3%	0.1%	0.1%	0.0%	0.0%	0.0%	0	0
■1-9	0.2%	4.0%	15.7%	19.6%	9.7%	19.5%	7.5%	1.3%	0.7%	0.4%	0.1%	0.0%	0.0%	0	0

Rate Change
min -44.6% max 77.9%

NH Insurance Department
February 11, 2003

Rate Changes Anticipated the First Year Small Group Reform is Effective
Assumed Trend at 12.5%



	-40%	-30%	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
25-50	0.0%	0.0%	0.0%	0.2%	0.3%	1.9%	1.2%	0.3%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
10-24	0.0%	0.0%	0.2%	1.4%	1.6%	6.1%	4.7%	1.3%	1.1%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%
1-9	0.0%	0.5%	3.8%	14.1%	11.1%	18.8%	15.9%	7.7%	4.8%	1.1%	0.5%	0.3%	0.1%	0.0%	0.0%

Rate Change
min -37.7% max 100.1%

NH Insurance Department
February 11, 2003

Attachment H

Testimony of Tom Welden CLU,ChFC, MSFS
Principal Financial Services Division
Eaton & Berube Insurance Agency, Inc.
Before the Senate Insurance Committee
Regarding SB 110
March 18, 2003

Hello, my name is Tom Welden and I am a Principal of the Financial Services Division of Eaton & Berube Insurance Agency, Inc. located in Milford and Nashua. We insure over 200 individuals and/or families for individual medical insurance and around 200 Companies for Group medical insurance covering thousands of employees. Everyone we speak to is very concerned about the cost of healthcare in NH and about the rising numbers of uninsured in NH.

I support trying to take legislative action on this issue and do support changing small group to 1-50; however I do not support all the other pieces of this legislation.
Let us start with what primarily drives cost of medical insurance, about 20% is due to administrative cost the other 80% is due to provider costs. SB 110 will increase the administrative costs X %; my guess is at least 5% and has no affect on provider costs, thus once again increasing costs of medical care. Medical Underwriting is an expensive and time-consuming process, which would cause carriers to provide brokers like myself, quotes two different times, the first from the census; the second time after underwriting was done. Rating business today for small groups is relatively easy; if this bill is passed rates will be set based on three pieces of information-medical underwriting, industry and geography thus increasing the costs dramatically of generating rates. Small businesses are already aware of the cost of hiring an older employee we will now be encouraging more discrimination in hiring by increasing the 3-1 to a 4-1 ratio and by having medical underwriting. Is this something we really want to do?

Dropping self-employed individuals or companies who only insure one employee due to others being covered by a spouse, I feel is a big mistake. If I were to offer you the BC/BS Blue Direct plan, one of the better plans in the market, would you like to be covered by a plan that has a maximum of $1,000 a year for prescriptions, meaning that if you had a major illness such as cancer or heart disease that you could run out of benefits in 30 days? Keep One-person groups and raise the premium accordingly so that they are not a loss leader, but don't get rid of them.

This legislation is supposed to attract new carriers to New Hampshire to make the market more competitive, I feel that this is a pipe dream. We have three major carriers in the state, two (BC/BS and Cigna) who cover the whole state and who have contracts with providers giving them deep discounts and Harvard Pilgrim who has been actively marketing and growing in the state over the last three years and is still covering less than 10% of the population of NH. New carriers coming in will be lucky to pick up 2-3% of the population and will be competing against carriers who have better contracts and discounts with providers-so where will the rate reduction come from?

This legislation will increase costs; drive more older and less healthy individuals into the ranks of the uninsured by shifting medical cost from the young to old and from the healthy to the less healthy. Overall, costs will not go down but up, just making the problem worse.

What can we do? First, I support a house amendment, which is coming, that asks for claim experience for all size groups. I would request that it goes one step further, requiring all carriers to supply meaningful experience not just two numbers, premiums paid and claims paid, that are now required. Supply information by category, not individual, such as ER use, inpatient and outpatient utilization, claims by drug class-generic, brand name or preferred brand name and the number of large claims. This would allow employers and carriers to provide education to employees based on how the plan is being used so that costs could be reduced thus reducing medical premiums.

Second, I suggest we need information (already requested but not provided by the carriers) on experience of one-person groups versus 2 to 9 person groups and 10 to 25 and 25 to 50. Rates could then be adjusted for groups of these sizes off of the largest group 25-50. Example 25-50 $1.00, 10-25 $1.05, 2-9 $ 1.15
groups of "One" $ 1.25 –adjusted for what these different size groups actually cost. This would lower the rates of the largest groups and increase them for smaller groups but still allow access to good medical coverage for all size groups. This would be inexpensive to do versus rating based on medical underwriting, industry and geography.

Last, we have revived the Individual market and now we need to enhance it by making comprehensive "solid" programs available to both the standard and high risk markets, something we do not currently have.

Thank you for listening to a concerned Health Insurance broker and citizen who has been serving his New England clientele for 30 years. I will be glad to answer any questions.

Attachment I

Testimony of:

LISA M. CARROLL, M.S., M.P.H., R.N.
Vice President, Small Business Service Bureau, Inc. (SBSB)
554 Main Street
Worcester, MA 01615

Senate Bill 110 (S.B. 110)
"An Act Relative To Small Group Health Insurance Coverage"

Senate Committee on Insurance

Room 101 LOB, 9:15 a.m.

March 18, 2003

Good morning Chairman Flanders, Vice Chairman Prescott and other members of the Insurance Committee. I appreciate the opportunity to testify today on S.B. 110, "An Act Relative to Small Group Health Insurance Coverage."

My name is Lisa Carroll. I am the Vice President of the Small Business Service Bureau, Inc. (SBSB). SBSB is a national membership organization of small businesses, including over 1000 small employers and their employees here in New Hampshire. SBSB provides legislative advocacy, management assistance, and group benefits and services to our members. Ten years ago I sat before this committee and applauded and supported the bold steps forward the New Hampshire legislature was making to reform the small group insurance market. Today, I am here to express my concerns about unraveling this progress and recreating the market instability that led to initial market reforms.

The four areas I wish to address are:

1.) The change in the group size definition of small employer
2.) The rating factors used to calculate small employer premium rates
3.) The introduction of health risk assessments for rating purposes, and
4.) Qualified Association Trusts.

1. Group Size

   There are almost 50,000 small employers with 1-50 employees in New Hampshire. Over 35% of these companies are sole-proprietors with only 1 employee, the owner. Increasing the minimum group size to 2 employees will result in almost 18,000 small employers losing the protections they now have under existing small group reform laws. These are legitimate small employers, who you hope will be profitable and grow in size. They are not individuals and they should not be restricted to the limitations of the individual health insurance market.

   Several years ago when many states enacted reforms that increased the minimum group size to two, that legislative action resulted in the "dumping" of previously insured sole-proprietors and self-employed persons into the non-group and uninsured markets. Those left uninsured were older and/or had medical conditions that rendered them ineligible for the medically underwritten individual market. Medical expenses subsequently forced them out of business. No one wins in this situation, and the state ends up with the final burden.

   States that have previously defined small group as a minimum of two employees are now realizing the negative impact this requirement has had on the sole-proprietor population. Many are enacting legislation to allow sole-proprietors back into the group insurance pools. Denying access and availability of group health insurance for companies of one may be profitable for the insurance companies, but it results in more uninsured among a population usually willing and able to pay for group insurance.

2. Rating Factors

The proposed rating changes are likely to drive up premiums significantly for thousands of New Hampshire's smallest businesses based on the health status, age of employees and type of business.

To calculate a small employers rates as a result of this bill, an insurance carrier would start with the base rate, then adjust by:

- age (4:1)
- group size (+20%)
- industry classification (+20%)
- geographic location (+15%)
- health risk status of employees

In the end, the small group could end up with rates over 80% higher than when they applied!

Small businesses are struggling to survive and are having difficulty meeting their current health insurance payments. New Hampshire's small business owners, particularly those with older employees, will find their premiums jump significantly with the expansion of the age-band ratio. And, employers in industries considered "high risk," ranging from health care and social service to construction, auto repair, lodging and transportation are likely to see their health care premium rates jump as well, if industry codes are introduced into the rating methodology mix.

These rating factors ultimately will work against many of the state's small businesses by increasing their costs at a time when they can least afford it. SBSB encourages the legislature to carefully analyze these rating factors and the full impact they will have on affordability and availability of health insurance for your small business constituents.

3. Health Risk Assessments for Rating Purposes

We considered it progress, when over 10 years ago the use of medical questionnaires to determine insurability were eliminated. Using medical questionnaires will further segment the small group market, enabling some insurance carrier to come into New Hampshire and "Cherry Pick" the young, healthy lives. And what about those left behind? Which carriers will insure them, and at what cost? "Cherry-picking" healthy insurance risk was eliminated years ago, I ask the legislature to deliberate very carefully before it is reintroduced in this State.

Despite provisions in the bill to mitigate the impact of using health status as a rating factor, the reality is that small businesses with employees, or covered dependents, with high utilization of health care services are going to see their rates skyrocket. Those with high blood pressure, heart disease, diabetes or other conditions requiring aggressive care, are likely to experience double digit premium hikes. Some employers may attempt to control their costs by not covering the employee responsible for driving up the rates. And what if it's a dependent? I have seen the use of health questionnaires in the small employer market significantly damage employee/employer relationships. In these situations, the result always is the same....someone is left uninsured.

4. Qualified Association Trusts

QAT's have had many past lives. They have been called MEWA's, HIPC's, AHP's, and "grandfathered associations". They are nothing more than another pooling mechanism in which healthy, new business risk is offered a low rate to attract membership. Then as the underwriting cycle continues, within 3-5 years the claims experience of the pool begins to erode, renewal rates increase dramatically, and the pool begins its decent into a "death spiral."

Establishment of Qualified Association Trusts will lead to risk segmentation in the market. Small businesses in lower risk industries with healthier than average employees would be able to purchase coverage through the Trusts while higher risk industries with less healthy employees would not have the same access. As the better risk moves into this market, it leaves those remaining small employers less able to purchase health care at affordable rates.

My fear is that the clock will be turned backward, and costs will spiral significantly higher for many small businesses, if New Hampshire's reform efforts over the last decade are unraveled. And, I fear that the cumulative impact on some of the state's smallest businesses under the bill's proposed rating and underwriting methodology, will be devastating, particularly given that 96% of all business in New Hampshire have less than 50 employees.

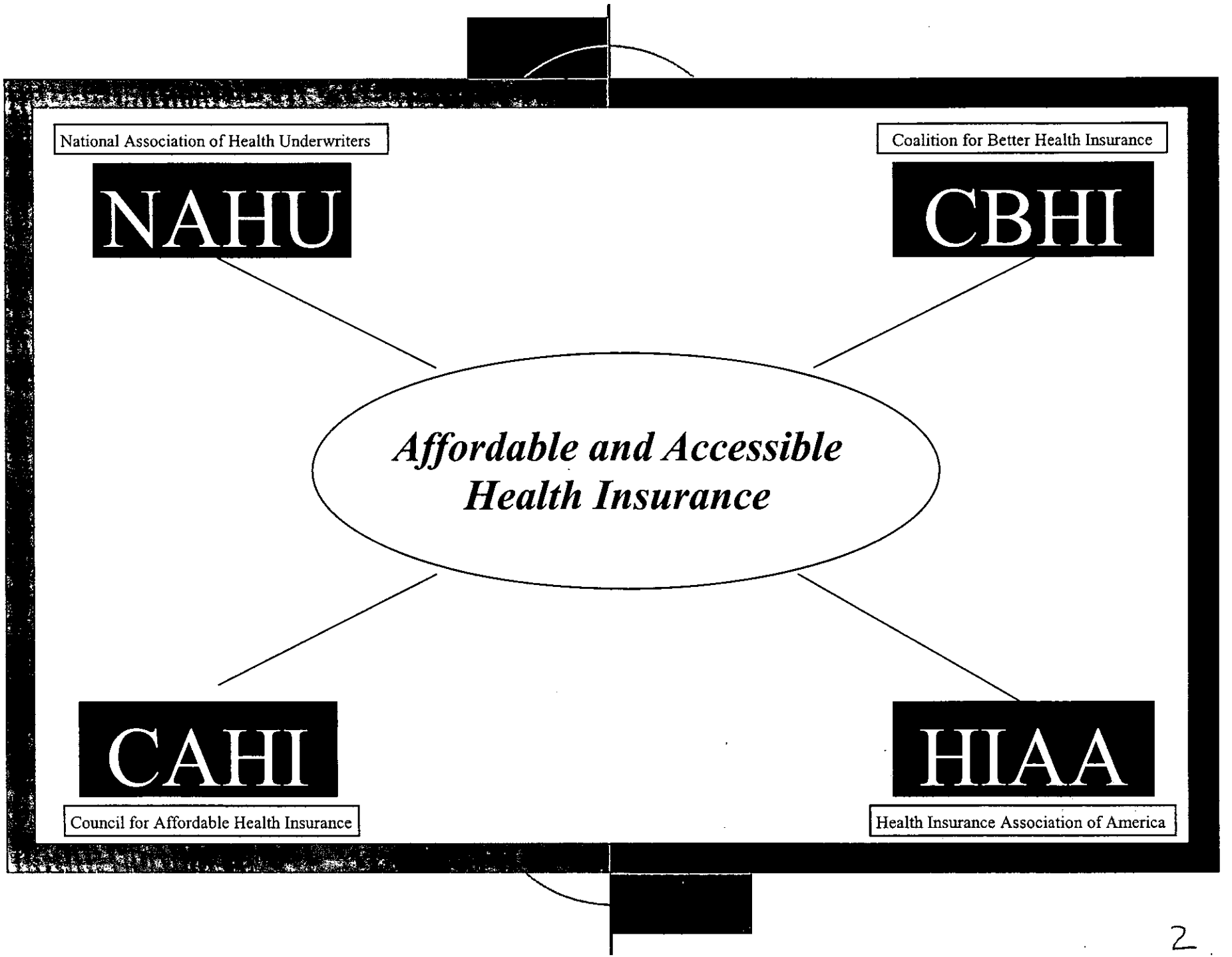
SBSB requests the committee fully study the implications of this bill on access, affordability, and availability of health insurance for these constituents before moving forward.

Thank you for the opportunity to testify before the committee.

Attachment J

Senate Bill 110
Group Health Insurance Reform

Testimony Submitted by: Raymond M. White, CLU
Chartered Financial Consultant
Health and Employee Benefits Chairman
New Hampshire Association of Insurance and Financial Advisors


National Association of Health Underwriters
NAHU
Coalition for Better Health Insurance
CBHI
Affordable and Accessible Health Insurance
CAHI
Council for Affordable Health Insurance
HIAA
Health Insurance Association of America

CAHI

The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, MSA and senior markets. CAHI's membership includes insurance companies, small businesses, providers, nonprofit associations, actuaries, insurance brokers and individuals. Since 1992, CAHI has been an active advocate for market-oriented solutions to the problems in America's health care system.

The mission of the Council for Affordable Health Insurance is to develop and promote free market solutions to America's health care challenges. CAHI has played a major role in Congress and state legislatures by educating lawmakers and regulators regarding the positive results or adverse consequences of reform measures.

Source: Council for Affordable Health Insurance (CAHI) Website

HIAA

The Health Insurance Association of America (HIAA) is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. It is the nation's premier provider of self-study courses on health insurance and managed care.

Among other initiatives HIAA supports:

1. Preserving the employer-based system of health coverage
2. Preserving choice in the marketplace
3. Improving access for the uninsured
4. Establishing limits on class action litigation
5. Opposes MEWA's or federal exemptions to the state-regulated market

Source: Health Insurance Association of America (HIAA) Website

CBHI

The mission of the Coalition for Better Health Insurance (CBHI) is to provide for the affordability and accessibility of health insurance, while improving competition for the benefit of all New Hampshire residents and employers.

The members of the Coalition are representatives of the three largest agent associations in the State, which include:

1. The New Hampshire Association of Health Underwriters
2. The Independent Insurance Agents of New Hampshire
3. The New Hampshire Association of Insurance and Financial Advisors

Who has sponsored the Bill?

Senate

Sen. Russell Prescott (r)
(PRIME SPONSOR)

Sen. Robert Clegg (r)
Sen. Thomas Eaton (r)
Sen. Robert Flanders (r)
Sen. Charles Morse (r)

House of Representatives

Rep. Mark Carter (r)
Rep. Rogers Johnson (r)
Rep. Robert Letourneau (r)
Rep. Robert Wheeler (r+d)

Companies that have exited New Hampshire since the implementation of SB 711 in 1995

1. Principal
2. Arbella
3. United Chambers
4. Trustmark
5. Travelers
6. Time
7. Provident Life & Accident
8. U.S. Life
9. Phoenix Home Life
10. Boston Mutual
11. United Plans
12. New York Life
13. New England Life
14. Colonial Benefit
15. Conseco
16. New England Life
17. Fortis
18. Oxford Health Plans
19. Chubb Life
20. Mutual of Omaha
21. Continental Life
22. Fidelity Security
23. Tufts Health Plan
24. Prudential
25. Anthem
26. Golden Rule
27. Nationwide
28. Central States of Omaha
29. ProHealth
30. US Healthcare

COALITION FOR BETTER HEALTH INSURANCE

93 Stiles Road, Suite 101
Salem, New Hampshire 03079

Representing New Hampshire Association of Health Underwriters (NHAHU), Independent Insurance Agents of New Hampshire (IIANH), and New Hampshire Association of Life Underwriters (NHALU)

8

A Coalition for Better Health Insurance has been established between the New Hampshire Association of Health Underwriters (NHAHU), New Hampshire Association of Life Underwriters (NHALU), and the Independent Insurance Agents of New Hampshire (IIANH).

We are in the process of drafting legislation to improve the health insurance industry of New Hampshire as it relates to access, affordability, competition, and hospital / physician contracting. Also, we are attempting to attract additional carriers to the State of New Hampshire to provide either individual or group insurance or both.

We are actively in discussions with the Department of Insurance, Department of Health and Human Services, State Legislature, and other interested parties to provide detailed solutions to the complex problems which face the health insurance consumer of New Hampshire.

None of the associations in the coalition are have expressed any support or opposition as a group to any of the reforms listed below. Rather, we are soliciting feedback from current, past, and prospective carriers to provide factual basis to potential legislative initiatives for the current legislative session.

We are very interested in your feedback regarding the potential solutions to health care reform and respectfully request an expeditious reply to our inquiry. In addition to your response we are interested in the your assessment of the priority of each item, as such, on a scale of 1 to 10 with one representing the least interest please provide your assessment of the item. We need to know what impact you would expect from these reforms, if your market position in New Hampshire would change resulting from the reform, and any other helpful information.

Thank you in advance for your consideration.

DEADLINE FOR RESPONSE IS OCTOBER 20, 1999

GROUP MARKET: 1 TO 10, WITH ONE REPRESENTING LEAST INTEREST

_____ 1. Would you be in favor of redefining small group (currently at 1 to 100) to any of the following? _____ 1 to 50 _____ 2 to 50 _____ other. Please provide a detailed explanation.

_____ 2. Would you be in favor of allowing geographic area rating? If yes, what would be a reasonable, maximum differential in premium between the most expensive area versus the least expensive? 10%, 20%, 30%, etc.

_____ 3. Would you be in favor of allowing industry rating, to be included as case characteristic? If yes, what would be a reasonable, maximum differential between industry? 10%, 20%, 30%, etc.

_____ 4. The current community rating model provides a 3:1 ratio. Is the current ratio appropriate or would your company prefer bands of 4:1, 5:1, or other?

_____ 5. Would you be in favor create a "Very Small Employer" definition, to be provided to an employer who provides insurance for 1 to 9 employees? If yes, what is a reasonable, maximum cost differential between the 1 to 9 versus 10 and above? 10%, 20%, 30%, etc.

_____ 6. Would you be in favor of providing increased rates due to health history at policy issue date?

_____ 7. Would you be in favor of carriers having the ability to increase renewal rates up to a maximum amount? If yes, what would your determine the most appropriate maximum rate?

_____ 8. Would you support the release of claims experience for any group not defined as small group?

_____ 9. Would you allow for exceptions under the 37 1/2% requirement to allow for network disruptions or inadequacy?

OTHER: Please provide any other detailed suggestions or ideas which will assist us in achieving our objective.

Healthiest States in the U.S.A.

1	New Hampshire	18	Virginia	35	Delaware
2	Minnesota	19	New Jersey	36	North Carolina
3	Massachusetts	20	Idaho	37	Texas
4	Utah	21	Kansas	38	Nevada
5	Connecticut	22	Indiana	39	Kentucky
6	Vermont	23	Pennsylvania	40	Georgia
7	Iowa	24	Montana	41	West Virginia
7	Colorado	24	California	42	New Mexico
9	North Dakota	26	Wyoming	43	Florida
10	Maine	27	Ohio	44	Tennessee
11	Washington	28	Maryland	45	Alabama
11	Wisconsin	29	Michigan	46	Oklahoma
13	Rhode Island	30	Alaska	47	Arkansas
14	Hawaii	31	Illinois	48	South Carolina
15	Nebraska	32	New York	49	Mississippi
16	South Dakota	32	Missouri	50	Louisiana
17	Oregon	34	Arizona		

Source: The United Health Foundation State Health Rankings 2002
http://www.unitedhealthfoundation.org/shr2002/index.html

How does New Hampshire currently compare to other states in regard to current group rate up for health status?

Rate Band	State(s)
+/- 0.00%	CO, CT, ME, MD, MA, NH, NJ, NY, OR, RI, VT, WA
+/- 10.00%	CA
+/- 15.00%	FL
+/- 20.00%	AL, NM, NC, ND, VA
+/- 25.00%	AR, GA, IL, IA, KS, KY, MN, MS, MO, MT, NE, OK, SC, SD, TX, WY
+/- 30.00%	NV, UT, WV, WI (LA is +/- 33%)
+/- 35.00%	AK, DE, IN, OH, TN
+/- 50.00%	ID
+/- 60.00%	AZ
No Restriction	DC, HI, MI, PA

The Coalition for Better Health Insurance recommends legislation that allows carriers to rate for medical underwriting at issue of new groups, +/- 25.00 from a base rate.

Source: Health Insurance Association of America (HIAA). Data as of December 2002

How does New Hampshire currently compare to other states in regard to the current definition of small group?

Definition	State(s)
1 to 100	NH
1 to 50	CO, CT, DE, FL, HI, ME, MD, MA, MS, NC, RI, WA
2 to 50	AL, AK, AZ, AR, CA, GA, ID, IL, IN, IA, KS, KY, MI, MN, MT, NE, NV, NJ, NM, NY, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, WV, WI, WY
3 to 25	MO, LA (3-35)
No Statute	DC,

The Coalition for Better Health Insurance recommends legislation that redefines the small group definition to 2 to 50, as the majority of states do.

Source: Health Insurance Association of America (HIAA). Data as of December 2002

Summary of State Small Group Rating Restrictions

State	Group Size	Rate Band	Allowable Case Characteristics					
			Age	Gender	Geog. Area	Industry	Group Size	Tobacco
ALABAMA	2-50	+/- 25%						
ALASKA	2-50	+/- 35%						
ARIZONA	2-50	+/- 60%						
ARKANSAS	2-50	+/- 25%						
CALIFORNIA	2-50	+/- 10%						
COLORADO	1-50	+/- 25%						
CONNECTICUT	1-50	+/- 25%						
DELAWARE	1-50	+/- 35%						
WASHINGTON DC	-----	+/- 25%	No Premium Rate Restrictions					
FLORIDA	1-50	+/- 15%						
GEORGIA	2-50	+/- 25%						
HAWAII	1-50	+/- 25%	No Statute					
IDAHO	2-50	+/- 50%						
ILLINOIS	2-50	+/- 25%						
INDIANA	2-50	+/- 35%						
IOWA	2-50	+/- 25%						
KANSAS	2-50	+/- 25%						
KENTUCKY	2-50	+/- 50%						
LOUISIANA	3-35	+/- 33%						
MAINE	1-50	ACR						
MARYLAND	1-50	ACR						
MASSACHUSETTS	1-50	ACR						
MICHIGAN	2-50		No Premium Rate Restrictions					
MINNESOTA	2-50	+/- 25%						
MISSISSIPPI	1-50	+/- 25%						
MISSOURI	2-50	+/- 25%						

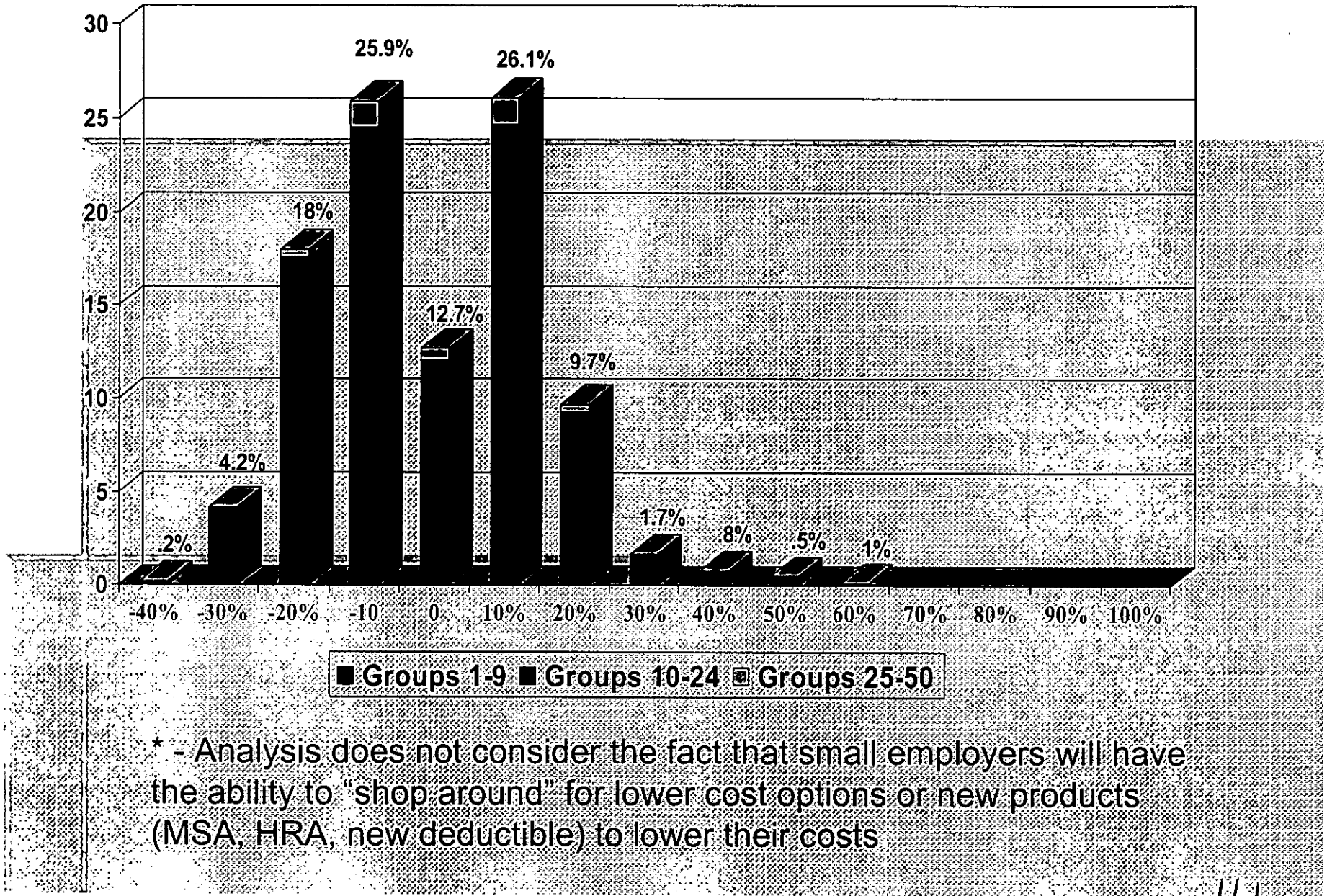
MONTANA	3-25	+/- 25%	■		■	■	■	■	
NEBRASKA	2-50	+/- 25%	■	■	■	■	■		
NEVADA	2-50	+/- 30%	■	■	■	■	■		
NEW HAMPSHIRE	1-100	ACR	■				■		
NEW JERSEY	2-50	ACR	■	■	■				
NEW MEXICO	2-50	+/- 20%	■	■	■				■
NEW YORK	2-50	ACR			■				
NORTH CAROLINA	1-50	+/- 20%	■	■	■	■			
NORTH DAKOTA	2-50	+/- 20%	■	■	■	■	■		
OHIO	2-50	+/- 35%	■	■	■	■	■		■
OKLAHOMA	2-50	+/- 25%	■	■	■	■			
OREGON	2-50	ACR	■		■				
PENNSYLVANNIA	2-50		No Premium Rate Restrictions						
RHODE ISLAND	1-50	ACR	■	■					
SOUTH CAROLINA	2-50	+/- 25%	■	■	■	■	■		
SOUTH DAKOTA	2-50	+/- 25%	■	■	■	■	■		■
TENNESSEE	2-50	+/- 35%	■	■	■	■	■		■
TEXAS	2-50	+/- 25%	■	■	■		■		■
UTAH	2-50	+/- 30%	■	■	■	■	■		
VERMONT	1-50	PCR							
VIRGINIA	2-50	+/- 20%	■	■	■				
WASHINGTON	1-50	ACR	■		■				
WEST VIRGINIA	2-50	+/- 30%	■	■	■	■	■		■
WISCONSIN	2-50	+/- 30%	■	■	■	■	■		■
WYOMING	2-50	+/- 25%	■	■	■	■	■		
			48	37	47	34	34		22

* PCR: PURE COMMUNITY RATING
* ACR: ADJUSTED COMMUNITY RATING

■ : Insurance Company May Use This Rating Characteristic

GROUP SIZE: 2-50 34 STATES
1-50 13 STATES
OTHER 3 STATES

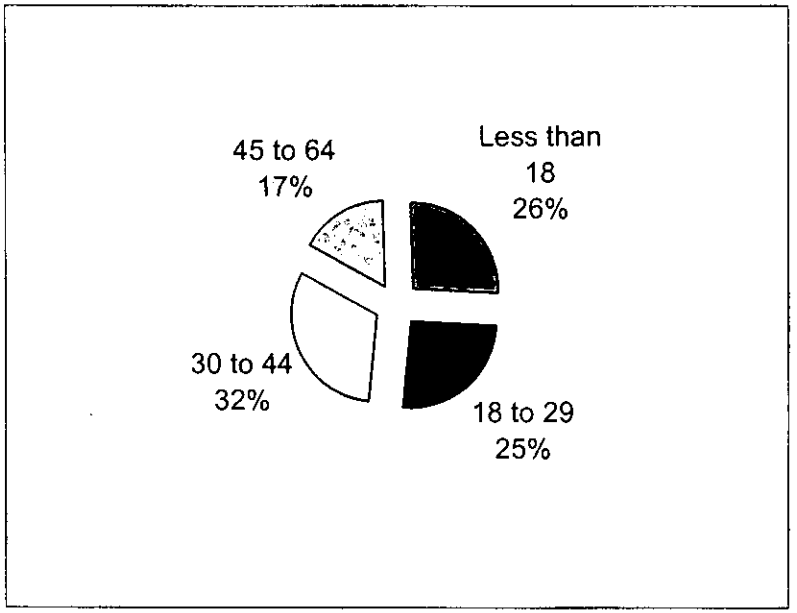
NHDOI Analysis: Impact of SB 110 on Current Rates*



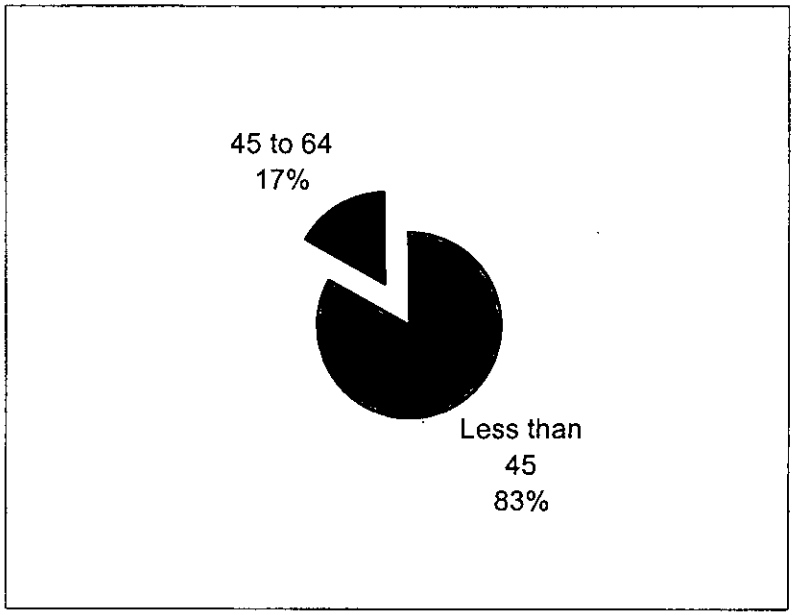
* - Analysis does not consider the fact that small employers will have the ability to "shop around" for lower cost options or new products (MSA, HRA, new deductible) to lower their costs

What are the demographics of the uninsured of New Hampshire

The Report from DHHS provided these statistics



The translation



Source: Health Insurance Coverage in New Hampshire, DHHS, Issue Brief 1999

The Coalition for Better Health Insurance

Representing: New Hampshire Association of Health Underwriters (NHAHU), New Hampshire Association of Insurance & Financial Advisors (NAIFA) and Independent Insurance Agents of New Hampshire (IIANH)

16

What do Small Group Rating Bands mean?

The NAIC rate bands recognize that we are imposing price restrictions in a voluntary and fluid marketplace. In order to achieve the positive result that public policy makers and regulators sought, they had to harness, not ignore market forces. The rate restrictions had to preserve the small group market's ability to attract and hold low-risk groups in order to support the spreading or sharing of risk.

Premium rate bands provide for a positive correlation in premium rates with the relative health status or expected claims experience of the group. The concept of rate bands also places both annual and aggregate maximum limits on the amount that premium rates can be increased based on the presence of high-risk health conditions or adverse claims experience. This is an important concept that helps ensure coverage affordability for small groups classified as high risk. Certainly, there are circumstances when a person's health condition is beyond their control. There are also circumstances where it is within an individual's control to make certain lifestyle choices. The annual and aggregate rating limits account for both scenarios.

The NAIC in its 1991 "Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups" model act advocated premium rating bands of +/- 25%. The range of +/- 25% represents the maximum permitted variation in premium rates (up or down) from the index or average premium rate for an insurers entire small group block of business in a state.

This variation in premium rates above or below the index rate is based on three factors:

1. The health status of group members;
2. Claims experience; and
3. Duration of coverage

The impact of all of these factors is restricted by the permitted variation imposed by the premium rate bands.

Under the 1991 NAIC model act, annual premium rate increases are based on three factors:

1. The change in an insurer's new business rate,
2. Any adjustments for changes in small employer case characteristics (e.g. changes in age and demographics), and
3. 15% (representing the maximum annual health status adjustment).

New Hampshire Small Group insurance laws permit insurers to modify premium rates based on change in an insurer's new business rate, age and family composition only. New Hampshire Small Group insurance laws, however, currently prohibit premium rate modification based on health status or claims experience.

The rating band structure enables insurers to more effectively compete with Employer Self-Funded markets for low risk business and to more effectively manage the risk and cost of guaranteed issue coverage of high-risk small groups.

Is New Hampshire Out-of-Step with the Majority of States?

Since the development of the 1991 NAIC model law, a majority of states have adopted some form of premium rate bands to regulate small group premium rating practices. A total of 39 states (over 75%) permit the use of rating bands. Of the states with rating bands in place, the most predominant rating range is +/- 25%. A total of 12 states (including New Hampshire) have adopted community rating or modified community rating thereby prohibiting premium rate adjustment based on health status or claims experience. The table below provides a by state summary of Small Group Rating restrictions.

17

Table

Summary of State Small Group Rating Restrictions

Rate Band	State(s)	
+/- 10%	CA	
+/- 15%	FL	
+/- 20%	AL, LA, NM, NC, ND, VA	
+/- 25%	AR, GA, IL, IA, KS, KY, MN, MS, MO, MT, NE, OK, SC, SD, TX, WY	39
+/- 30%	NV, UT, WV, WI	
+/- 35%	AK, DE, IN, OH, TN	
+/- 50%	ID	
+/- 60%	AZ	
No Restriction	DC, HI, MI, PA	
Community Rating (+/- 0%)	CO, CT, ME, MD, MA, **NH**, NJ, NY, OR, RI, VT, WA	12

Source: Health Insurance Association of America (HIAA). Data as of October 2000.

These rating parameters do afford the Small Group market enhanced ability to compete for low risk business and manage the financial costs associated with high-risk groups. The existence of a 15% maximum annual health status adjustment also affords consumer protections that limit the annual range of upward premium rate adjustments.

What Protections Are In Place to Protect Affordability of Coverage for High Risk Groups?

As stated above, there are significant protections in place to prevent high-risk groups from being priced out of the market.

1. The NAIC model has a 15% annual health status adjustment limit. This means that on renewal, an insurer is limited to a 15% maximum annual adjustment for the health status or claims experience of a group. This limits the upward premium rate adjustment for this factor.

2. Small group insurers must file their rates with the Department of Insurance and the Dept. has the ability to review the rates and determine if they are reasonable and justified.

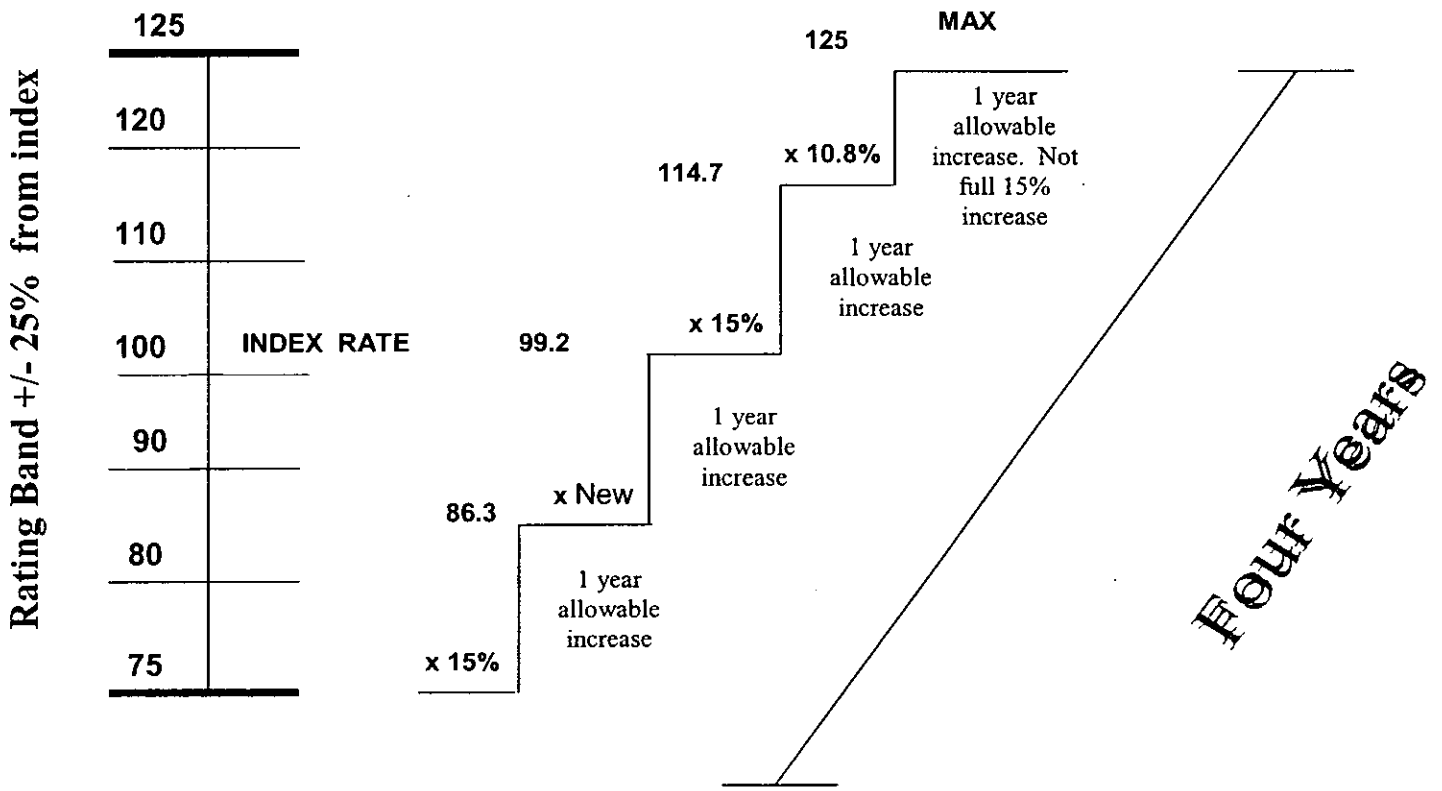
3. Competition in the market will dictate the appropriateness of the rates if an insurer wants to remain competitive. Tying the highest rate to the lowest rate with the band forces insurers to actively compete for the low risk business yet keep the highest rate within a reasonable range.

How Does the NAIC Model Work?

The table below is an illustration of how the +/-25% rating band model operates. Each step in the illustration represents a small employer group at their annual policy renewal. A low risk group entering the small group market represents the starting point at "75". This is –25% from the index rate. If health status or claims experience changes during the year for this particular group, the maximum rate increase the insurer can use attributable to the health status of the group is 15%. At this rate, it would take four years to reach the top of the rate band.

Opponents of rate bands claim that a low risk group could become a high-risk group within a year and therefore go from the bottom of the band to the top of the band with no protections and would be priced out of the market. As you can see from the illustration below, with a 15% maximum annual increase for health status, that scenario is simply false. Another important aspect to note is that a high risk group at the maximum (125) could drop to the middle (average risk) or the bottom (low risk) of the band in one year as competitive markets require that insurers annually update a group's health status risk tier in order to retain low and average risk business. In other words, there is no annual downward limit.

NAIC Model
+/- 25%;
15% Maximum Renewal Increase



NAHU Comments on the Efforts of the New Hampshire Coalition to Amend the Small group and Individual Health Insurance Markets in New Hampshire

Janet Stokes Trautwein
National Association of Health Underwriters: Director of Federal Policy Analysis

One of the biggest problems facing NAHU members across the country today is shrinking markets for small employer and individual health insurance. The most stable markets across the country are those where there is significant competition among many insurance carriers. This healthy environment invariably occurs when insurance carriers can rate appropriately for risk. Some of the healthiest markets we see for individual and small employer health insurance are those in states like North Carolina, Georgia, Texas, and Iowa, to name just a few. In these markets, HIPAA guidelines for small group are followed with groups characterized as 2-50, and there is the ability to rate up or down for the health insurance risk of the group, from 20-35% depending on the state. This allows carriers to rate appropriately the first time, and renewal increases tend to be smaller. Most of these states have no rules on age band rate differentials, in other words, there is no difference between what the youngest enrollee may be charged as compared to the oldest enrollee. In the small employer market, this ability to accurately assess risk comes with accountability, and small employers are protected against rate increases greater than 15%. Most states with this type of flexible rating structure have ten or more active carriers in their markets.

New Hampshire has a unique opportunity to change the disastrous effects of prior overzealous state health insurance reform. At this point in time, the excellent work of the coalition has produced an environment where significant change can occur, and a market on the downslide has a real chance for recovery. This may be a one-time opportunity, and it should be taken now.

First, carriers should be able to use the more typical definition of small employer, stopping at 50 lives instead of 100. This provides for a distinct cut off and is more attractive to carriers who specialize in the 2-50 market in other states. Federal and state rules relating to HIPAA and other state rules for small employers also normally stop at 50, and this is attractive to carriers who in the past were faced with significant system changes in order to operate in New Hampshire. At this time, it may not be feasible to bring one person groups back into the individual market (where they belong) but this should also be seen as a long term goal to complete the needed market changes, once the individual market is in a more healthy status.

The ability to rate for risk cannot be stressed enough, and will be a significant attraction for carriers who have not been active in New Hampshire for many years. The ability to rate up or down 20% for health risk and widening the age rate band rules from 3 to 1 to 5 to 1 is actually conservative compared to markets in some other states, and will be a draw for carriers who would be interested in participating in the New Hampshire market. The 15% limit on renewals again provides for accountability from carriers and is an incentive to underwrite properly during the initial enrollment process.

In the individual market, the recommendations made by the coalition are essential. In the most healthy individual markets around the country, there are NO restrictions on the

ability to rate for health risk, nor are their any rate band rules. Insureds who are declined for coverage in the regular market are eligible for coverage in state high-risk pools. It is worth noting, by the way, that most states' risk pool coverage is less expensive and has better benefits than the average health insurance policy sold in New Hampshire, so any notion that the consumer will be hurt by the creation of a High Risk Pool is inaccurate. The changes being suggested in the individual market to allow greater health risk underwriting margins, a widening of the rate band, and the ability to rate based on smoking status are in no way out of line and again, are still more restrictive than what is found in many other states.

NAHU has had the opportunity during the past couple of years to do some work with the General Accounting Office (GAO) as well as with the Kaiser Family Foundation and Georgetown University on small employer and individual health insurance markets across the country. The most recent projects we've worked on with these organizations will be released this spring, and we are not permitted to discuss results prior to publication, but when the reports are released you will find that they are consistent with our recommendations for health insurance reform in New Hampshire.

I'm attaching a chart summarizing health insurance reform across the country, along with a recent NAHU survey done of prices across the country in the individual health insurance market. I think you will find these helpful in your analysis of New Hampshire's situation.

In closing, I would reiterate that NAHU completely supports the changes being recommended by the coalition as in the best interests of New Hampshire consumers. Consumers are not served well by markets where few carriers and little competition exists. Invariably these markets produce higher costs and less choice for consumers. Now is the time to make changes, before the market shrinks further, and while strong legislative support exists for the change.

What affect will the recommended reforms have on the New Hampshire insurance market?

1. Will continue to provide GUARANTEED access to health insurance. (NO "cherry picking" allowed. MUST issue coverage to all eligible groups who apply).
2. Will have NO AFFECT on HMO Accountability and existing state mandates.
3. Modified rating variables will provide an incentive to younger individual to purchase health insurance, reducing the number of the younger "voluntary uninsured".
4. States with similar legislation have more carriers and more plan choices.
5. Within a competitive market, the cost of health insurance will be potentially reduced.
6. More plan design choices from more carriers (PPO, MSA, Indemnity, HRA designs), INCLUDING existing carriers as occurred in the individual marketplace post-reform.

What affect will the recommended reforms have on the New Hampshire insurance market?

7. Allow carriers to rate for medical underwriting at issue of new groups, +/- 25% from a base rate. (NAIC Model Law) These rating parameters afford the small group market enhanced ability to compete for low risk business and manage the financial costs associated with high-risk groups. Tying the highest rate to the lowest rate with the band forces insurers to actively compete for the low risk business yet keep the highest rate within a reasonable range.
8. Caps renewal premium increases due to an employer's bad claims experience at 15% annually. (NAIC Model Law) All renewal premiums have to remain within the +/- 25% of the base rate.
9. Geographic rating flexibility allows insurers and HMO's to add higher cost hospitals to their network, without impacting all other existing plans, rather than excluding them as some do now, restricting plan choices and creating near-monopolies in certain areas of the state.
10. Preserves State of NH DOI control– relives current pressure for unregulated AHP's.

Attachment K

NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Analysis of State-Level Health Insurance Market Reforms

January 2003

The National Association of Health Underwriters (NAHU) is a trade association that represents approximately 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance needs of millions of Americans. As an association of health insurance professionals, NAHU's two top public policy objectives are: (1) reducing the number of uninsured Americans through private-market solutions, and (2) making sure that state-level private health insurance markets are as vibrant and competitive as possible.

NAHU recognizes that state health insurance markets are both extremely diverse and complex. Certainly, market reforms that work well in one state might not work as effectively in another. Furthermore, no one state has what could be termed the perfect health insurance climate. However, the fact remains that some state health insurance markets work much more efficiently than others—more carriers compete in these markets, costs are lower and there are fewer uninsured. This paper will identify some of the key elements of successful health insurance markets, explain why these reforms are important, and give examples of why some state health insurance markets work, and why others have failed.

Key Components to Health Insurance Market Stability

Ability to Medically Underwrite in the Individual and Small-Group Markets

One of the most important characteristics of a successful state health insurance market is the ability for health insurers to accurately assess risk for policies sold to both individuals and small businesses. Health insurance is a risk management mechanism and the level of risk varies amongst the insured population. The price of health insurance must reflect these differences in risk, because if everyone paid the same amount for health insurance, only those with the greatest need for expensive medical care would purchase coverage, thereby creating a dysfunctional health insurance market.

The way carriers can accurately assess individual market and small-group risks is through the practice known as medical underwriting. In states that allow for this, each individual applicant or employee is required to complete an individual questionnaire with detailed health information on the employee and all family members to be covered. The underwriter normally uses only information obtained from the application, but sometimes the underwriter will request additional information from an applicant's physician or may telephone the applicant to clarify an item on the application. If an underwriter is unable

to obtain information necessary to accurately determine the risk of a particular applicant, he or she will underwrite more conservatively, meaning that the assumption relative to the missing information will be negative rather than positive. So, for example, if an underwriter sees that a person has a history of high blood pressure that is controlled with medication and has a weight within normal limits, but he or she is unable to determine whether or not the individual smokes and has a normal cholesterol level, the underwriter will assume that the missing information is negative.

All states but nine[1] allow for medical underwriting in the individual market, however, only 36 states[2] allow for medical underwriting in the small-group market. The ability of insurers to accurately assess risk is extremely important, particularly in markets such as the individual and small group markets where the ability to spread risk is limited, and is even more important in states that allow for self-employed individuals to qualify as business groups of one.

The most common type of state small-group rating law[3] allows groups to be rated 25 percent above or 25 percent below an "indexed" rate. The indexed rate is determined by averaging the lowest possible rate and the highest possible rate. Most states that have this type of rating system also have a limit on rate increases due to the health status of the group, which is helpful in stabilizing rates over time. Even with these initial rate fluctuations for a new group, small employer rates in these states tend to be much lower than in states where health status rating is not allowed. A group that is rated correctly up front is much less likely to have a very large increase at renewal, and in order to rate the group correctly, the correct information on the initial application is essential.

The alternative to medical underwriting is community rating or a modified form of this rating mechanism. Certain states employ the community rating mechanism, which requires insurers to charge all individuals who live in the same zip code the same exact premium regardless of their age or health status. So, for example, in a community-rated state, an employer would pay the same amount per month to insure a healthy 27-year old non-smoking male with no health conditions as it would to insure a 55-year old male smoker who is suffering from prostate cancer and a heart condition, simply because the two live in the same zip code.

A variation on this rating mechanism is known as modified community rating. In states that use this mechanism, health plans are allowed to vary the community rate based on limited factors, such as age, gender and/or smoker status. So, for example, in a state that allows modified community rating with variations for age, an insurer could charge more

---

[1] Maine, Massachusetts, New Jersey, New Mexico, New York, North Dakota, Oregon, Vermont and Washington all either require community rating or modified community rating in their individual health insurance markets.

[2] Arizona, Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New Mexico, Oregon, Vermont and Washington all allow for either modified community rating or community rating in their group markets.

[3] Thirteen states allow for small-group rate bands of +/- 25 percent. The other remaining 23 states either allow for rate bands that range from 10-50 percent, or allow for medical underwriting without rate bands in the small-group market.

for the 55-year old male smoker with cancer and a heart condition than for the 27-year old healthy male. However, the insurer would have to use the same rate when calculating premiums for the healthy 27-year old male as it would for a male co-worker who is the same age but suffers from juvenile diabetes. Also, it is important to note that state-level modified community rating laws vary greatly. Some allow for many adjustment factors, but many allow for just a limited few, such as gender, age and family composition only, like Colorado. Modified community rating has a severely negative impact on health insurance rates in all states that employ the mechanism, but the more limited the rate adjustment factors, the more severe the problem.

NAHU has observed that in all states with the community rating and modified community rating mechanisms, younger healthier individuals and workers are penalized since carriers cannot account accurately for these healthy risks. This leads to much higher overall health insurance rates than in the states that allow for the use of medical underwriting in the individual and small-group markets. In addition, since these laws make it much more difficult for health insurers to rate their products accurately, doing business in states with these requirements is much more costly. As such, fewer health insurers may offer plan options in these states, which in turn limits consumer choice, reduces competition and leads to overall price increases.

Appropriate Group Size Definitions

How states define and divide their health insurance markets also has a strong impact on market stability. State health insurance markets are generally divided into three categories—the individual, small-group and large-group markets. Individual markets serve people who for some reason do not have access to employer-sponsored health insurance coverage. In almost every state, the small-group health insurance market serves employer groups with less than 50 employees. One state, New Hampshire, defines a small-group as 100 employees or less. The majority of states define an employer group as at least two individuals, but 14 states allow for self-employed individuals to be considered a business group of one. Large-groups are typically defined as employer groups that have more than 50 employees.

In studying state-level health insurance markets nationally, NAHU has found that the most successful states define their group markets as follows—small-groups as 2 to 50 employees, and large-groups as 51 employees and above. The states that allow for business groups of one typically have much higher overall small-group rates for a variety of reasons. First of all, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health insurance be guaranteed issue for all employer groups. This is a requirement that only three of the 14 states place on their individual market carriers[4]. Guaranteed issue in the individual market and for groups of one has historically been a problem, because in a group of one, there is absolutely no means for an insurer to

[4] The three states that allow for business groups of one and mandate that all insurers in the individual market guarantee issue coverage to all individuals are Maine, New York and Vermont. In three other states, Hawaii, Maryland and Massachusetts, Blue Cross/Blue Shield currently voluntarily serves as the guaranteed issue carrier of last resort for the individual market.

spread risk. If an insurer has to cover all individuals who make up groups of one regardless of any medical conditions, then the insurer is forced to assume that each of these one-person groups is a medical risk, and rate all small-group products accordingly. In addition, in the nine states (Colorado, Connecticut, Delaware, Florida, Hawaii, Maryland, Mississippi, New Hampshire and North Carolina) that permit medical underwriting in the individual market, the laws create a perverse incentive for individuals with serious medical conditions to try and "game" the system and attempt to obtain guaranteed issue group coverage as a business group of one, even if they do not operate legitimate businesses. This is known as "adverse selection," which inevitably leads to higher rates for all individuals in the small-group market.

High-Risk Health Insurance Pools

NAHU has found that another key component to health insurance market stability in a state is the existence of a well-functioning, appropriately funded, health insurance high-risk pool for medically uninsurable and HIPAA-eligible individuals. High-risk health insurance pools have been created in 30 states[5] in order to provide affordable and quality private health insurance options for individuals with catastrophic medical conditions who do not have access to the group insurance market. The vast majority of these states also use these pools as an alternative mechanism to the guaranteed group-to-individual health insurance portability provisions required by HIPAA.

Risk-pool consumers are often self-employed individuals, early retirees or employees of small businesses that do not offer benefits. They generally have very serious preexisting medical conditions, such as cancer, diabetes, or another chronic illness that would cause them to be turned down if they applied for traditional private-market individual insurance. For most people who buy coverage in these pools, the risk-pool is an intermediate coverage solution. The average amount of time an individual spends in a risk-pool is 30 months, since many individuals eventually obtain group coverage or qualify for Medicare or another government-sponsored health insurance program.

High-risk health insurance pools help stabilize insurance markets, because they allow insurers to segment the severely unhealthy people seeking individual coverage, but still offer these individuals access to private market coverage. Consumers that need to purchase coverage in the high-risk-pool have access to comprehensive private-market coverage options that might not otherwise be available to them. These individuals pay higher rates than other individual market consumers, but these rates are capped, generally at about 125-200 percent of the average individual market rate. This arrangement benefits both consumers and insurers. Consumers are provided with a very important safety net, and insurers are provided with a predictable means of accounting for uninsurable risks. This allows individual market carriers to keep rates much lower for all traditional consumers, and since state laws cap risk-pool participant premiums based on

[5] The states that have created health insurance high-risk pools are: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

the average individual market rate, the high-risk consumers also significantly benefit from these lower rates. Furthermore, small-group health insurance carriers and consumers also greatly benefit from stable high risk-pools, since the availability of a risk-pool in a state significantly decreases the risk that a person with a serious medical condition will try and "game" the system and obtain guaranteed issue group coverage. This, in turn, helps keep small-group rates in the state much lower.

In addition to the existence of a high-risk health insurance pool, stable funding for the pool is crucial. State risk-pool rates are capped, and because the individuals that utilize the pool often have the highest possible loss ratios, premiums alone would never be sufficient to satisfy claims. Therefore, the 30 states that have created high-risk pools to serve their individual health insurance markets have also established additional funding mechanisms to offset pool losses. State funding sources for high-risk pools range from legislative appropriations, to tobacco settlement funds, to hospital use surcharges. The most common funding source is some type of assessment levied on health insurance carriers in the state. While NAHU favors a specific type of carrier assessments for offsetting risk-pool losses, our organization has found that the most important item necessary in creating a successful risk-pool is selecting a stable funding source.

Examples of states that have had problems with pool funding instability in the past include California, Florida, Illinois and Louisiana. All of these states have had to either limit enrollment, implement waiting lists, reduce services and/or close their pools, in order to deal with funding shortfalls. In addition, due to the current status of many state budgets, states that use funding mechanisms like appropriations, tobacco settlement revenues and assessments with premium tax credit offsets, such as Utah, Kentucky and Arkansas, respectively, have indicated that they are likely to encounter funding troubles in the future.

File and Use vs. File and Approve

NAHU has also found that state regulations regarding the filing of health insurance rates also have an important impact on market stability, especially in the individual and small-group markets. In most states, states allow insurers to simply file their rates with the state insurance departments and then immediately be able to "use" them. However, in some states, insurers are required to submit their rates to the state department of insurance for approval prior to use. This can be problematic, especially in the individual market, where rates are more volatile, due to the inability of health insurance carriers to spread risk. Rate increases in "file and approve" states tend to be higher than in "file and use" states because carriers have to build in reserve funds for every rate increase request, to compensate for the possibility of future rate change denials. In addition, "file and approve" requirements can hinder carriers from bringing new insurance products into the market in a timely basis, which also hurts consumers, since it can limit choice in health products.

Limits on Mandated Benefit Laws

Another important component of a stable state health insurance market is a limited number of health insurance mandated benefit requirements. In recent years, the number of mandated benefit laws, or laws that place requirements on the content of private health benefit plan contracts, have increased significantly. Mandate laws range from statutes that require health plans to cover services by particular types of providers (e.g., chiropractors, optometrists), requirements to cover specific diagnostic or treatment services (e.g., mammography, infertility) or laws to extend certain benefits to certain populations (e.g., continuation coverage of employees or health plan liability). While individual mandates are often very popular since they are intended to provide specific populations with greater access to particular services, there is a cumulative price tag associated with ensuring such access. The sheer volume of mandated benefit laws being passed in the states has caused health insurance premiums to rise substantially. Research shows that there are now over 1000 benefit mandates in existence, and various studies indicate that they have caused health insurance premiums to increase as much as 25 percent[6]. Therefore, an increase in the number of mandates that are imposed leads to more people being priced out of health insurance, further swelling the ranks of the uninsured. A large number of health insurance mandates hits the small-group and individual health insurance markets particularly hard, since larger employer groups are more likely to self-insure, thus exempting them from state-level mandated benefit laws, as provided by the federal Employee Income Retirement Security Act of 1974 (ERISA).

Certain states, like Maryland (57 state mandated benefit requirements) and Connecticut (49 state mandated benefit requirements)[7], lead the pack when it comes to mandates. However, in recent years, many states have taken action to curb state-level mandated benefit requirements, as one way to keep health insurance costs under control. States have taken various approaches to this task. Virginia, for example, with 47, has a very high number of mandated benefit requirements. However, six of those mandated benefit requirements, including some of the more expensive mandates, like morbid obesity treatment and bone marrow transplants, are mandatory offer laws.[8] This means that employers and individuals only have to be given the option of choosing policies that include those benefits. This can substantially reduce costs for employers and individuals, since they do not have to select the benefits that do not meet their individual needs. Twenty-five states[9] have requirements that all mandated benefit proposals go through some type of cost-evaluation before enactment. However, in only five of those states, Maryland, Pennsylvania, South Carolina, Virginia and Washington, are those cost review impact studies mandatory and completed on a regular basis. Finally, a few states, like North Carolina and Oregon, have passed legislation in recent years limiting the number

[6] Source: Jensen, G. and Morrissey, M. "Mandated Benefits Laws and Employer-Sponsored Health Insurance." Health Insurance Association of America, January, 1999.
[7] Source: Blue Cross Blue Shield Association. "State Legislative Health Care and Insurance Issues; 2001 Survey of Plans." January 2001.
[8] Ibid.
[9] Arizona, Arkansas, Colorado, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin are the states with mandated benefit evaluation laws.

new mandates that can be enacted, due to the impact those mandates have on health insurance costs in the states.

Appropriate Regulation of Managed Care Carriers

While the problem of appropriate regulation of managed care carriers has only arisen in a few states, it can be a very serious impediment to market stability. The vast majority of states make the appropriate distinction in their laws between health maintenance organizations (HMOs) other types of managed care health insurance products, such as preferred provider organization (PPOs). HMOs exercise a great deal of control over the health care treatment of their policyholders, while PPOs typically do not strictly control the medical treatment of policyholders. However in a few states, like Rhode Island, all managed care insurance companies, including both PPOs and HMOs, are considered "health insurance issuers" without any regard to the particular products they offer in the marketplace. The result is that all of the operations of the insurance company, including non-HMO products, become subject to the requirements of the state's HMO law.

Unlike HMOs, PPOs simply make decisions concerning the reimbursement of health care expenses of policyholders based upon the insurance contract. Additionally, PPOs do not use a gatekeeper or require referrals from a primary care physician in order to see a specialist. However, in states where PPOs are subject to all HMO requirements, these plans can be forced to implement very expensive and unnecessary reforms, such as hiring a full-time medical director. NAHU has found that placing additional regulation on entities that only finance health care services creates additional financial burdens on these companies without any benefit to consumers. The result has been massive carrier withdrawal from these states. For example, Rhode Island is down to one individual market insurer, two small-group insurers, and four large-group insurers. In Alabama, there are only two companies actively writing policies in the state.

Ability of Plans to Develop Appropriate Networks

Another important characteristic of a successful state health insurance market is the ability of health insurance plans to be able to develop strong networks of providers, and to be able to effectively negotiate discounts with those providers. This is critical for both health insurance plans and health insurance consumers, since plans need to be able to negotiate with a wide range of quality providers in order to both attract customers and to keep costs low, and consumers benefit from having a wide range of doctors from with which to choose.

Several states have enacted measures that make it difficult for plans to develop a comprehensive and effective network of providers. For example, a number of states require health plans to accept any willing provider who meets their plan criteria into their networks. The vast majority of these states limit these measures, so that they, for example, only apply to pharmacies. However, Idaho and Kentucky extend these requirements to all providers. Any willing provider mandates may seem like they would benefit consumers, since they allow the greatest number of providers into a plan, but

these laws actually have a serious negative consequence. Since any doctor who wishes to participate with a plan can, it makes it much harder for carriers to negotiate any discounts with providers, since there is no financial consequence for non-participation. This leads to higher medical reimbursement costs for all plans in the states, which translates into higher insurance rates for consumers.

Another way states can limit a health plan's ability to negotiate with providers is through the passage of an antitrust exemption for physicians in a state. Currently, when doctors and other healthcare providers negotiate their contracts for services rendered with health benefit plans, they must abide by state and federal antitrust laws that prohibit them from engaging in collective bargaining. However, legislation has been passed in Alaska, New Jersey and Texas that gives physicians and other health care professionals immunity from those antitrust laws and allows them to bargain collectively according to the same rules that apply to organized labor groups who are governed by the federal National Labor Relations Act.

Competition keeps healthcare costs down in the private sector, as well as in the Medicare and Medicaid programs, and these antitrust laws help eliminate competition amongst healthcare professionals by permitting them to engage in price-fixing, boycotts and market allocation agreements that would otherwise be illegal under the antitrust laws. Advocates for these measures have claimed that they are necessary to help providers protect consumers, but that is not really the case. Antitrust waivers are needed to enable providers to collectively discuss health plans issues involving legitimate quality-of-care concerns or bring such issues to the attention of the public. The 1996 Department of Justice/Federal Trade Commission guidelines state that such discussions are permitted under the current antitrust laws as long as they do not involve boycotts or other collective activity that could limit the choices available to consumers. The reality is that these measures are simply a means for providers to band together to negotiate higher fees, which only hurts health plan consumers by increasing health insurance rates.

Allow For the Widespread Availability of Different Plan Choices

Perhaps the most important element of a successful state health insurance market is the availability of a wide variety of plan options for consumers to choose from. Competition lowers prices, and with many competitively priced plan options out there, less people will go uninsured. States can help ensure that individuals have a wide array of plan options by implementing laws that allow for the introduction of innovative products in their markets, such as medical saving accounts. But the most important thing a state can do to ensure a greater degree of consumer choice is to make sure that the state maintains a regulatory and legislative environment that encourages many health insurance carriers to actively market products in the state.

Accurately tracking the number of health insurance carriers actively marketing in a state can be problematic, since HIPAA requires a five-year ban on reentry for all carriers that officially withdrawal from a state health insurance market. As a result, many carriers get around this requirement by simply limiting their marketing efforts, or by only servicing

current policyholders. As such, state insurance department records of the number of health insurance carriers in a state are not always precise.

However, NAHU has found a high degree of correlation between the states that do not always follow the criteria listed in this paper for successful health insurance markets and states where health insurance producers report a high rate of insurance carrier exodus. Furthermore, in these states we also have seen evidence of higher rates, and higher number of uninsured individuals. As such, NAHU strongly recommends that states allow for the use of medical underwriting in the small-group and individual markets, prohibit business groups of one, create high-risk pools, allow rates to be filed and then immediately used, limit the number of mandated benefit requirements, regulate PPO plans appropriately, and allow for the development of effective plan networks. This will keep health insurance rates down, the level of competition high, and the number of uninsured as low as possible.

State Markets That Work

Virginia

The Commonwealth of Virginia is one of the more attractive environments for health insurance carriers to do business in the United States, for several reasons. First of all, in Virginia, health insurance carriers are able to fully underwrite both individuals and small employer groups based on medical history. Furthermore, the definition of a small employer for the purposes of obtaining health insurance is one that employs between two and 50 individuals, and the state maintains tight controls to ensure that qualifying businesses are legitimate and actually employ at least two people.

Virginia does not have a high-risk health insurance pool for medically uninsurable people in the individual market, but Trigon Blue Cross/Blue Shield, the largest health insurance carrier, serves as the carrier of last resort for people with catastrophic health conditions, in exchange for tax advantages from the Commonwealth. As such, Trigon essentially functions as a private high-risk pool, and all of the state's other individual market carriers derive similar benefits from Trigon's actions as they would if Virginia had a traditional high-risk pool in place. Furthermore, Virginia's small-group market benefits from the individual market stability, just as it would if a risk-pool were in existence. As a result, for the size of the state, there are a large number of carriers competing in the market place, rates are relatively low for individuals and businesses, and only 11.9 percent of the state's population goes without health insurance, compared with the 14.5 percent national average.[10]

This is not to say that Virginia's health insurance market is entirely problem-free. Health insurance rates in Virginia have climbed in recent years, just as they have nationwide. The difference is, though, that cost increases in Virginia can primarily be attributed to overall rising medical costs, instead of rising medical costs combined with regulatory

[10] Source: U.S. Census Bureau. *Health Insurance Coverage: 2001.* "Table 4. Percentage of People Without Health Insurance Coverage for the Entire Year by State (Three-Year Average): 1999 to 2001."

costs and lack of competition, as is the case in many states. Also, the number of mandated benefit laws in Virginia remains very high, but as explained earlier in this paper, a number of the most expensive mandates are "mandatory offer" requirements, as opposed to "mandatory inclusion," and the state has one of the few effective mandate evaluation boards operating in the country.

Illinois

Another state with a very stable health insurance market is Illinois. Carriers in Illinois are not subject to any rating restrictions in the individual market, and in the small-employer market, carriers can medically underwrite their products as long as they stay within rate bands of plus or minus 25 percent. The small-group health insurance market serves employers with between 2-50 employees, and the state has a moderate number of health insurance mandated benefit requirements, with 32 mandates currently on the books. Perhaps the most important facet of Illinois' market stability is the regulatory climate it provides to health insurance plans in the state. Illinois not only allows for the "file and use" of health insurance rates, but the state has also been cited by several major insurance carriers as providing one of the friendliest regulatory environments to carriers in the country, which helps make plans want to do business in the state. As a result, the market is extremely competitive, and consumers in Illinois benefit from the correspondingly low health insurance rates.

One area where Illinois could stand some improvement concerns its high-risk health insurance pool. The pool has been serving high-risk people in the individual market since 1989, and is in many ways extremely effective. However, Illinois splits the way it funds losses incurred by its risk-pool. Losses for traditionally medically uninsurable individuals are funded by direct appropriations from the state, whereas losses for HIPAA-eligible individuals who enter the pool exercising their guarantee-issue rights are funded by assessments on health insurance carriers in the state. As a result, the HIPAA-eligible portion of the pool has always had a stable source of funding, but the medically uninsurable portion of the pool has faced periodic challenges. In order to meet funding restrictions, Illinois has had to impose a cap on enrollment for medically uninsurable people, and this has sometimes caused the state to have to implement a waiting list for pool coverage. NAHU feels that the medically uninsurable component of the risk pool in Illinois would greatly benefit from a more stable funding source, and it is our hope that the recent availability of federal funding for state high-risk pools will help spur a legislative change in the state to create a more stable funding base for this segment of the pool.

Texas

Texas is a good example of a very large state with a vibrant health insurance market capable of serving its population's varied needs. In Texas, individual market carriers are able to fully medically underwrite their products without restriction, and small-group market carriers are subject to rate bands of plus or minus 25 percent. Furthermore, a small group in Texas for health insurance purposes is between 2-50 employees, and the state has had a high-risk health insurance pool serving its medically uninsurable and HIPAA-eligible populations since 1999. Carriers in Texas are able to "file and use" their

health insurance rates, and health maintenance organizations and preferred provider plans are regulated appropriately.

One area where the Texas market could stand improvement, though, concerns laws that may make it more expensive for health plans to do business in the state, and for plans to develop effective networks. Texas is one of only two states (New Jersey is the other) that has enacted legislation allowing for physicians to apply for a waiver to antitrust laws in order to band together and collectively negotiate fee-based contract provisions with carriers that the state determines have market dominance in a given area. In addition, Texas is one of only twelve states[11] to pass health plan liability legislation, which has been estimated to raise costs by between 2.7 and 8.6 percent,[12] and the state is tied for third place in the number of mandated benefit laws on the books with 47.

Finally, the uninsured rate in Texas is extremely high—on average 23 percent of the population went without health insurance for a year or more between the years of 1999 and 2001.[13] However, this high rate of uninsured individuals may be partially explained by geography. Texas is a border state, with a high Hispanic-American population rate. For a variety of reasons, Hispanic-Americans have a higher incidence rate of being uninsured than other groups, and Hispanic-Americans that qualify for Medicaid are less likely than non-Hispanic qualifiers to sign up for the program, thereby often causing them to go uninsured.

State Markets That Are In Trouble

Rhode Island

The private health insurance market in Rhode Island is on the verge of collapse. In 2001 and 2002, the state witnessed a number of carriers leave both the individual and small-group health insurance markets. According to the state Department of Business Regulation's Division of Insurance, currently, only one carrier is actively marketing policies in the individual market and one carrier is merely servicing existing policyholders. In the small-group market, two carriers are actively marketing policies, and for large-groups, there are four carrier options available. In NAHU's view, several factors have contributed to this state's carrier exodus.

First of all, the state does not make a regulatory distinction between HMOs and PPOs. As such, all carriers who operate PPO plans and serve more than 1,000 policyholders in the individual market and more than 10,000 policyholders in the small-group market are required to follow all of the same very stringent and expensive regulatory requirements of an HMO plan. Since PPO plans, due to their structural differences, are generally much less expensive than HMO plans to operate, this regulatory environment has made it cost-

[11] Arizona, California, Georgia, Louisiana, Maine, New Jersey, North Carolina, Oklahoma, Oregon, Texas, Washington and West Virginia have all passed health plan liability laws.

[12] Barents Group. *Impact of Four Legislative Provisions on Managed Care Consumers, 1999-2003.* April 22, 1998.

[13] Source: U.S. Census Bureau. *Health Insurance Coverage: 2001.* "Table 4. Percentage of People Without Health Insurance Coverage for the Entire Year by State (Three-Year Average): 1999 to 2001."

prohibitive for most carriers to offer PPO products in the state. Those that do offer PPO products are faced with a perverse disincentive to grow their customer base beyond 1,000 lives in the individual market and beyond 10,000 lives in the small-group market, as doing so would significantly increase costs beyond the profitability level.

Some other problems in the state include the lack of a permanent option for medically uninsurable individuals in the individual market, and a "file and approve" requirement for all health insurance rates. Currently, Blue Cross and Blue Shield of Rhode Island, which is the only carrier actively marketing an individual product in the state, voluntarily offers guaranteed issue coverage to people seeking coverage in the individual market, regardless of health condition. However, the individual product this carrier offers has limited major medical benefits, and high-risk individuals can easily exceed the lifetime maximum benefit in rather short order. As a result, many Rhode Island residents with catastrophic medical conditions who do not have access to group coverage are currently uninsured, and have no legitimate options for obtaining private coverage. Rhode Island's "file and approve" requirement for health insurance rates has also been cited by several health insurance carriers as an impediment to doing business in the state, since the requirement restricts carriers ability to adjust rates based on economic and market changes, and it can also hinder the ability of carriers to bring new products to market in a timely fashion.

Finally, legislation that was enacted several years ago and is slated to go into effect in 2003 and 2004 is making it difficult to attract new health insurance carriers to the state. Currently, the state allows for limited medical underwriting in its small-group market, with rate bans of plus or minus 10 percent. Also, the state currently defines a small-employer group as 2-50 employees. However, beginning in October of 2003, reforms will go into effect in the state that will eliminate medical underwriting in the small-group market and instead call for the use of modified community rating. Also, the definition of small-group will be changed so that business groups of one will be eligible for guaranteed issue group health insurance. When combined with the competitive hurdles that already exist for health insurance carriers in this state, these forthcoming reforms have prevented any new health insurance carriers from entering this market since the carrier exodus began in 2001.

Florida

The private health insurance market in Florida has been on the decline for some time. And while a variety of factors have contributed to this decline, the most significant factor, in NAHU's view, is the state's lack of a mechanism for providing coverage to medically uninsurable people in the individual market. Florida technically has a high-risk health insurance pool in existence, but the pool has been closed to new applicants for the past eleven years due to funding woes. Since there is no adequately functioning risk-pool, the state requires that all individual carriers guarantee issue coverage to individuals exercising their HIPAA group-to-individual portability rights, at great expense. For people seeking private individual market health insurance coverage who are not HIPAA-eligible and are declined for coverage due to health conditions, there are no legitimate options available.

This lack of a high-risk pool has caused serious repercussions in the state's individual market, as well as in the small-group market. No means of covering individuals with serious medical conditions other than the group market would be problematic in any state, but it is particularly troubling in Florida, where the warm climate attracts a huge number of early retirees. Early retirees frequently do not have access to group medical insurance benefits, and they are also disproportionately likely to have one or more medical conditions that would hinder their ability to qualify for traditional medically-underwritten individual health insurance.

Since carriers are forced to take HIPAA-eligibles on a guaranteed issue basis, participating in the Florida health insurance market is particularly expensive. Many carriers attempt to make up for large HIPAA-eligible losses by imposing particularly strict medical underwriting criteria on the rest of the individual market. Many other carriers have deemed it too expensive to write traditional individual insurance in the state, and instead operate in the market in a limited fashion under the state's out-of-state-group law. This peculiarity in Florida state law allows non-domiciled carriers to sell products in the state under limited regulation by the state Department of Insurance. While this loop-hole has allowed the state's individual market to stay relatively competitive under adverse market conditions, it has also led to some carrier abuses like the use of re-underwriting in the individual market, as well as in a proliferation of sham association health plans being marketed in the state.

The effects on the small-group market in Florida have, in many ways, been even worse. Florida allows for the sale of guaranteed issue group coverage to one-life groups. And since there is no functioning risk-pool, many people with serious medical problems who can't obtain individual coverage seek to obtain coverage through the individual market by claiming to be self-employed. The result has been the creation of hundreds of thousands of one-life groups in Florida over the past few years, and the high loss-ratios associated with these groups have caused rates for the entire small-group market to skyrocket.

To further complicate the problem, Florida does not allow for true medical underwriting in their small-group market. Instead, Florida utilizes the modified community rating mechanism. Reforms enacted in 2000 enabled insurers to use health status on a very limited basis as one of the factors allowed in determining rates, but this is not the same as allowing complete medical underwriting, and thus has not had the desired effect on rates. During the 2002 legislative session, a measure was passed that allows one-life groups to be segmented from the rest of the small-group market and rated separately, but it remains to be seen what impact, if any this will have on overall small-group rates.

Colorado

The Colorado small-group health insurance market has been experiencing an exodus of carriers for several years, and in NAHU's view the problem can be traced primarily to two significant factors—the use of modified community rating for products sold in that market, and the existence of one-life employer groups. Currently, carriers in Colorado can only adjust rates based on the limited factors of age, geographic location and family

composition. As such, carriers in this market have no means of underwriting products based on health status, which has caused rates in the state to skyrocket.

Another serious problem is that the Colorado small-group market is plagued by adverse selection. This is due in part to the fact that the state allows business groups of one to purchase guaranteed issue group coverage. The volume of claims associated with one-life groups is significantly higher than with larger groups where there is more spreading of risk. Furthermore, one-life groups in Colorado tend to purchase coverage on an episodic basis, with the average contract length being only nine months. Other factors contributing to adverse selection in the small-employer market are ironically the state's competitive individual market and unique state laws that make it relatively easy for even very small healthy groups to self-fund, and therefore qualify for exemption from state mandates as rating laws, as provided by ERISA.

Another impediment to competition in Colorado is the state's "file and use" procedures. While the state does have a "file and use" law, there are frequent delays, which can make it difficult for carriers to prospectively manage risk and protect their business. The state would greatly benefit from revised "file and use" rules that would allow new rates to be utilized immediately upon filing.

The end result of all of these problems is that in 1994, before rate reforms were instituted in Colorado, 83 carriers marketed health insurance in the state. Currently, the small-group health insurance market in the state is served by only 12 carriers, with only four carriers offering coverage in the vast rural portions of the state.

State on the Rebound

New Hampshire

In 1995, the New Hampshire health insurance market was relatively healthy and competitive, with 34 carriers offering health insurance products. However, reforms enacted in the 1990s eliminated the use of medical underwriting in the state and required that individual market health insurance products, as well as group health insurance products, be offered on a guaranteed issue basis. Furthermore, the state is the only one in the nation that defines a small employer for the purpose of providing health insurance as an entity that employs between 1-100 individuals. As a result, the state's health insurance market began to rapidly deteriorate and costs began to rise, so that by 2000, the state was down to five carriers offering health insurance products, with two of those carriers dominating 90 percent of the small-employer market.

During the 2001 legislative session, members of the New Hampshire Association of Health Underwriters worked with legislators, health insurance carriers, business groups and other insurance agent trade associations on reform measures to repair the state's private health insurance market. This effort was largely successful, and legislation was passed that eliminated the guaranteed issue requirement for individual market health insurance, allowed for the use of medical underwriting, and created a high-risk health insurance pool, amongst other changes. Based on these legislative changes, one very

large insurance carrier immediately agreed to re-enter the New Hampshire individual and small group markets, and subsequently, since the risk-pool has become operational, several other carriers have begun to market new products in New Hampshire, and costs are already beginning to drop.

However, the New Hampshire health insurance market still has some room for improvement. The vast majority of the reforms tackled during the 2001 legislative session focused on improving the individual market. During the upcoming legislative session, New Hampshire members plan to address small-group reforms, including revising the state's group size definition. It is expected that completing these additional reforms will further attract new carriers to the state.

Conclusion

As a professional association of benefit specialists, NAHU members occupy a unique role in the health insurance marketplace. On a daily basis, our membership works with both individual and corporate health insurance consumers to help provide them with the type of coverage that best serves their individual needs. As such, NAHU members have an excellent understanding of what kinds of health insurance markets best serve consumers effectively. And after years of researching state health insurance markets nationally, NAHU has found time and time again that states that create perverse incentives for individuals to forgo health insurance coverage while driving up the cost of insurance for those who maintain it through anti-market "reforms" like guaranteed issue, mandates or community rating, have only exacerbated the growing problem of the uninsured. Conversely, states that have implemented market-friendly measures, such as high-risk pools, "file and use" laws, and measures that do not hinder the development of extensive health plan networks, have higher degrees of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured. NAHU urges all states to implement the market-friendly reforms discussed in this paper, and we look forward to working with state and federal-level policymakers to ensure that our goals of reducing the number of uninsured and ensuring vibrant and competitive health insurance markets in all states are achieved.

NOTE: This document is the exclusive property of the National Association of Health Underwriters. It was prepared as an information resource for NAHU members, state and federal policymakers and other interested parties. It is not to be duplicated, copied or taken out of context. Any omission or inclusion of incorrect data is unintentional. If you have any questions about the information presented in this document, please contact Jessica Fulginiti Waltman, NAHU Director of State Government Affairs at either (703) 276-3817 or jwaltman@nahu.org.

Attachment L

Harvard Pilgrim Health Care

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

TESTIMONY OF BETH ROBERTS
DIRECTOR, NEW HAMPSHIRE BUSINESS OPERATIONS
HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND
BEFORE THE SENATE INSURANCE COMMITTEE
REGARDING SB 110

MARCH 18, 2001

Good morning. My name is Beth Roberts. I am the Director of New Hampshire Business 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 2 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.

Harvard Pilgrim Health Care of New England, Inc.
160 South River Road, Suite 201
Bedford, New Hampshire 03110
603-656-9500

Excluding groups of 1 from the small group market would also be a positive step. Because of changes in state law that took effect last year, groups of 1 now have the option of purchasing coverage either in the medically underwritten individual market and the guaranteed-issue small group market. While enrollment into the small group market is limited to March and September, we are still concerned that adverse selection will occur. Over time, this may result in higher small group rates than would result if groups of 1 were required to purchase coverage through either the individual market or state's high risk pool.

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 current small group market, and Harvard Pilgrim believes that it warrants further legislative study. 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 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.

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

Attachment M

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

Anthem.

March 18, 2003

Senate Insurance Committee
SB 110: Small Group Health Insurance Market Reform Act

Submitted By: Yvonne Nanasi, Government Relations Director

Anthem Blue Cross and Blue Shield (Anthem BCBS) is concerned that SB 110 will cause significant disruption in the small group market for several employers and may not fulfill the goal of increasing the number of small business employees who have health insurance.

Comparisons with Other States

When reviewing the data from the other states that allow the type of rating bands proposed in SB 110, it is significant to note the prevalence of small group employer coverage. With very few exceptions, all of the community rating states (alike to NH) have a significantly higher rate of health insurance coverage in the small group market that those who allow + - 25% rate bands for underwriting factors proposed in SB 110. In fact, those who allow such rate bands are have the lowest percentage of small employer health insurance coverage in the nation (see attached spreadsheet and graph based on Kaiser Foundation state data reports).

Furthermore, 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 State Budget that is being considered by the legislature.

The recently enacted individual market reforms that provided for similar underwriting factors and a high-risk pool in the individual market was touted as needed to attract new insurers into the market. Thus far, the number of insurers has not increased substantially in this market and, in fact, one has just announced that it is leaving the state.

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 2-50 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.

USA

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

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.

Employers that are "a group of 1" will no longer be defined as a "small group" and will be required to purchase insurance in the individual market

The individual market allows insurers to offer higher premiums or deny coverage to those who have high-risk medical indicators. Those who are denied coverage or have certain medical conditions can purchase insurance in the state's high-risk pool. In this market, the products offered tend to have higher deductibles and are not required to offer many of the mandated benefits required of employer group insurance.

IMPACT OF NEW RATING FACTORS THAT CHANGE HOW PREMIUM IS CALCULATED

Employers with 2 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.

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 65%-92% more than other businesses.

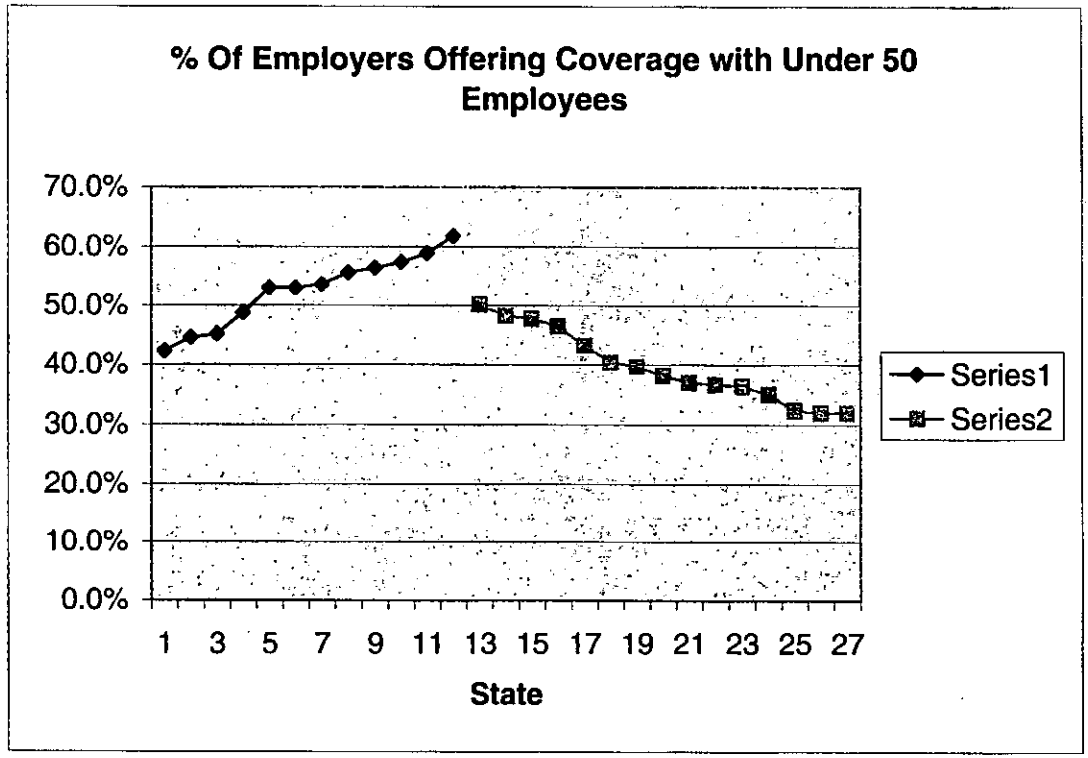
SUMMARY

As the Blue Cross and Blue Shield plan licensee in the state, Anthem BCBS is committed to providing health insurance coverage to individuals and employers in New Hampshire. New Hampshire's status as a state that has 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 medical providers are working. What is working needs to be retained and SB 110 may not accomplish that goal.
SB 110 is a radical shift from the current method of calculating health insurance premiums for small employer groups. A similar radical shift has not shown much result in the individual market in attracting new carriers into the market.
This radical shift may need 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.

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 and the cost savings can be in the same range as the rating factors proposed in SB 110 without discrimination against those with health conditions. Benefit options with MSA alternatives and other benefit options are becoming available without SB 110.

Anthem BCBS is available to assist Senators in their deliberations on SB 110 and provide any assistance that is requested.

State	Community Rated	(+, -) 25%
ME	42.3%	
OR	44.6%	
MD	45.2%	
WA	48.8%	
CO	53.0%	
VT	53.0%	
NY	53.6%	
NH	55.6%	
NJ	56.4%	
RI	57.4%	
MA	58.9%	
CT	61.8%	
KY		50.2%
IL		48.3%
KS		47.8%
MO		46.5%
MN		43.3%
IA		40.5%
SC		39.7%
GA		38.2%
TX		37.0%
OK		36.7%
MS		36.4%
NE		35.1%
WY		32.4%
AR		32.0%
SD		32.0%



Humana Pre-Quote/Risk Assessment Form

Sales Person: _____ Sales Office: _____

Company Name: _____ Quote #: _____

Agent Name: _____ Is this the agent of record? ☐ YES ☐ NO

SIC Code: _____ How Long? _____

1) Does the group have a current healthcare carrier? ☐ YES ☐ NO

   a) Carrier Name: _____

   b) Renewal Date: _____

2) The number of different carriers your group has had in the last 5 years: _____

3) The number of employees currently eligible for group coverage under your plan: _____

4) The number of employees currently enrolled for coverage under your plan: _____

5) The percent of premium the employer will be contributing to the employee premium: _____

6) In accordance to YOUR company records, and to the best of your knowledge, answer the following questions:

   a) Has any employee missed 10 consecutive days of work in the past 12 months due to illness or injury? ☐ YES ☐ NO

   b) Is any employee NOT performing his or her duties on a full-time basis due to an illness or injury? ☐ YES ☐ NO

   c) Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period:

   * Currently confined at home, in a hospital, or any treatment facility? ☐ YES ☐ NO

   * Had more than $10,000 of medical expenses in the past 24 months? ☐ YES ☐ NO

   * Been advised within the past 90 days to have surgery or be hospitalized? ☐ YES ☐ NO

   d) Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist, or other licensed practitioner within the past 24 months for any of the following: (check all that apply)

   ☐ AIDS or an AIDS-related complex or other immune system disorder

   ☐ Alcohol or drug abuse or dependence, or psychological disorder

   ☐ Cancer or cancerous tumor

   ☐ Heart or vascular disease, or stroke

   ☐ Diabetes or any disease or disorder of the kidneys, liver or lungs

   ☐ Systemic disease such as Lupus, Multiple Sclerosis, or Muscular Dystrophy

   ☐ Organ transplant (other than corneal)

For any "YES" answers given to the above questions, please provide additional information below for each individual. If additional space is needed, please use a signed and dated addendum.

Question #	Member Type	Age	Medical Diagnosis/Condition	Dates of Treatment	Medication Name/Dosage	Past/Current/Future Treatment

* Member Type E = Employee, C = COBRA, D = Dependent, R = Retiree

7) Has YOUR company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?

☐ YES ☐ NO If yes, please provide details: _____

Humana Pre-Quote/Risk Assessment Form

8) Have any medical benefits now, or within the past 24 months been partial self-funded or self-funded by YOU in any manner other than health insurance premium payments? ☐ YES ☐ NO

If YES, please provide details AND attach medical claims experience and monthly enrollment in the plan within 3 months of the proposed effective date (up to 24 months in arrears).

9) Are retirees under the age of 65 eligible for coverage under your plan? ☐ YES ☐ NO

If YES, the number of retirees under the age of 65 for coverage under your plan is: _____

10) If medical coverage is requested, provide the current and renewal Medical insurance premium rates below AND attach a copy of your most recent premium bill. Please indicate the number of individuals covered in each tier in the renewal rates portion below.

Current Plan Design

HMO

Office Visit Copay _____

Network Name _____

ER Copay _____

Per Confinement Copay _____

Rx Benefit _____

# of employees in each tier

EE _____ EE+CH _____

EE+SP _____ FAM _____

PPO/POS

Office Visit Copay _____ Plan Design _____

Network Name _____ ER Copay _____

Rx Benefit _____

Deductible (IN) $ _____ (OUT) $ _____

COINS (IN) $ _____ (OUT) $ _____

# of employees in each tier

EE _____ EE+CH _____

EE+SP _____ FAM _____

CURRENT RATES (Please indicate if current and/or renewal rates include prescription drug coverage)

HMO

Employee	$	Spouse	$
Child(ren)	$	Family	$

PPO/POS

Employee	$	Spouse	$
Child(ren)	$	Family	$

RENEWAL RATE

HMO

Employee	$	Spouse	$
Child(ren)	$	Family	$

PPO/POS

Employee	$	Spouse	$
Child(ren)	$	Family	$

Under no circumstances should you cancel your present group insurance coverage without written notice of approval from Humana insurance.

This proposal is intended to help Humana insurance underwrite your firm's requests for group insurance. This form must be completed by an officer of your company who knows, or can obtain, the healthcare history of the company's employees and their dependents. The officer should complete this form on the basis of that information and to the best of that officer's knowledge. Additional information may be required on employees who are required to answer medical questions, for any conditions not disclosed on this form. This information could potentially impact underwriting's final decision.

Completed By: _____ Title: _____

Date: _____

Attachment N

March 6, 2003

Mr. Raymond White
Cornerstone Benefit & Retirement Group
P. O. Box 10487
Bedford, NH 03110-0487

RE: SB110 Small Group Reform Legislation

Dear Ray,

Thank you for the invitation to the Healthcare Forum scheduled on March 13, 2003 in Concord, NH.

UnitedHealthcare has always been a strong proponent of Small Group Reform. We applaud the initiatives of the associations that have continued to work effortlessly to change reform laws in NH to allow more competition and a level playing field in NH.

UnitedHealthcare supports SB110 as the bill proposes the same key provisions that were previously introduced to NH legislators several years ago. Also, UnitedHealthcare provided testimony stating the proposed changes would benefit the NH small group employers at the Senate Hearing.

UnitedHealthcare in the past, and going forward, continues to offer quality products in the State of NH. With the proposed reform laws for SB110, this will enable UnitedHealthcare and other group health carriers to offer more competitive products to the community as the proposed reform changes would provide a level playing field for all insurance carriers.

Ray, I look forward to attending the Joint Healthcare Forum on March 13th, and wish you all much success in this endeavor.

Sincerely,



Donald E. Croisetiere,
VP of Small Group Sales
New England Region

Attachment O

SB 110
Possible questions at the media briefing

Q - Will sole proprietors lose insurance?

- No, federal law requires that sole proprietors that have existing group insurance be grandfathered, and they will have the option of continuing to purchase that same coverage through their current carrier.
- If enacted, a sole proprietor purchasing insurance for the first time would purchase insurance through the individual market.
- SB 110 also establishes rate restrictions for existing groups of one through 2005.
- Currently NH is the only state in the country that defines the small group market as businesses with between 1-100 employees and the bill would change that to 2-50 employees. This policy is currently in place in 37 states and DC and the federal government.

Q - Won't this bill return us to the days of "cherry picking" and insurance company activities that led us to enact community rating in the first place?

- No, the health insurance environment is much different now than in 1994. SB 110 preserves guaranteed issue and renewability laws and sets strict limits on insurers ability to rate customers. These laws and limits were not in effect in 1994.
- SB 110 will restore competition to the small group market with strict limits on underwriting.
- SB 110 establishes policies that are similar to 30-38 other states that have competitive markets with a variety of products for small businesses.

Q - Doesn't this bill just create winners and losers, with the already at-risk populations being the losers?

- Under the current law everyone is losing. According to the federal government, NH small businesses pay some of the highest rates in the country for family and single person coverage, and there is no end in sight for these increases.
- These high premiums translate into lower wages and cost sharing for employees, and a competitive disadvantage for companies in NH trying to compete across state lines.
- According to the NH Department of Insurance, most of the small group market will experience insurance rate reductions as high as 40% if this bill is enacted.
- If SB 110 is enacted, NH will have a competitive small group insurance market with a wide variety of insurance products. If a small business gets a rate increase from their existing carrier, they will have an opportunity to "shop around" for other insurance products that meet the needs of their business and employees. This option does not exist now.

Q - Opponents claim that similar policies enacted in the individual market have made no difference. Is that true?

- That law has only been in effect since July 2002, however, the competitive market has been restored, prices have come down and consumers have a variety of products to choose from.
- There is a wider variety of products in the individual market now than in the small group market.
- In fact, Anthem Blue Cross/Blue Shield has reduced its prices by more than 65% since individual market reforms were enacted, and we expect to see further premium reductions this spring.

Q - Some claim that small businesses will experience 70% increases in insurance costs if this bill is enacted?

- Under SB 110, prices will no longer be dictated by the insurer to the small business community as they are now. Instead, small businesses will have a choice of insurance companies and products, and will have the ability to "shop around" for the products that best meet their needs.
- If an insurer gives a company as 70% premium increase, I think they can expect to lose that customer to a competitor if SB 110 is enacted.

Q - Doesn't that really mean the small businesses will choose a lower benefit product in order to reduce costs?

- Remember that this is the trend now under our current laws. Employers are looking at cutting benefits or sharing costs with employees just to keep up with the cost increases under community rating.
- SB 110 would bring new options for small businesses. If one benefit plan is too costly or the design isn't compatible, employers will have a choice of products.
- NH small businesses can expect to have insurance options that they have never had before, including medical savings accounts and health reimbursement accounts. Options that have never come to NH because of our extreme insurance laws.

Q - Won't larger businesses of 50 or more employees face large cost increases when they are put into the large group market?

- NH is the only state in the country that includes groups of 50 to 100 employees in the small group market.
- There is evidence that these larger groups drive up costs for smaller companies because large companies are able to self-insure and then jump back into the regulated market when they have a problem.
- It is likely that these larger companies will have the same insurance company and product options that they have now, plus many more.
- The large group market is now a competitive market, so if a business gets a large increase from their insurer you can expect that they will "shop around" for a different carrier and product.

Q - Won't geographic rating increase costs for businesses in the North Country?

- The impact of geographic rating will depend on each insurer. Some insurance companies will utilize geographic rating and others probably will not.
- The health insurance market in the North Country has even less choice than other parts of the state, and allowing insurers to price their products to reflect regional cost differences may encourage some carriers to stay in the North Country and allow other insurers, who only operate in the southern part of NH, to begin offering products up there.

Q - What assurances do you have that insurance companies will return to the state if SB 110 is enacted?

- It is important to remember that it took eight years to drive the market to the position it is in now, and establishing a competitive market will not happen overnight.
- The goal of the bill is to have NH laws be consistent with a majority of other states, so if SB 110 is enacted there will be no reason for insurers not to return.
- We do have assurances from some companies that they will return and from other companies that are still in NH but have not been actively marketing their products for many years.
- People both within state government and within the insurance industry are actively working to make companies aware of the bill and encouraging them to open up shop in NH if SB 110 is enacted.
- Our experience with similar changes in the individual market has been positive both in terms of reducing prices and increasing the amount of products offered.

Attachment P

The Coalition for Better Health Insurance

Health Status Rate Bands

How they help ensure health insurance coverage for high-risk groups and encourage competition in the marketplace

As part of SB110, which is currently being considered by the New Hampshire State Legislature, a health status rating band would be implemented that would afford insurance carriers in the small group market enhanced ability to compete for low risk business and manage the financial costs associated with high-risk groups. Tying the highest rate to the lowest rate with the health status rating band forces insurers to actively compete for the low risk business, yet keeps the highest rate within a reasonable range for small businesses.

Q: What is current New Hampshire law regarding rating bands?
A: Current state law utilizes modified community rating, which severely limits health insurers' ability to vary rates due to the amount of risk they are insuring or the amount of claims they pay (which is why most insurers have left NH). By prohibiting insurers from varying premiums based on various risk factors presented by a group, community rating makes true insurance impossible. The result is invariably the destruction of the private insurance market and a reduction in coverage as young, healthy companies abandon policies they can no longer afford. Under community rating we've seen New Hampshire go from a low cost state to one of the highest for employer based health insurance.

Q: What would SB110 implement regarding health status rating bands?
A: It would enable insurance carriers to use health status rating bands of +/- 25 percent for small groups. This policy is encouraged as part of the National Association of Insurance Commissioner's (NAIC) model act and is used in a majority of states. The range represents the maximum change in premium rates from an average premium rate for an insurer's entire small group business in a state.

Q: Is New Hampshire out of step with a majority of other states?
A: Yes. Since the development of the NAIC model, a total of 35 states have adopted some form of premium rating bands to regulate small group premium rating practices (DC, HI, MI, PA have no restrictions). Of the states with rating bands in place, the most common used is +/- 25 percent. Only 12 states, including New Hampshire, have adopted a community rating or modified community rating which prohibits premium rating adjustments based on health status or claims experience.

Q: How do rate bands help ensure coverage affordability for small groups classified at high risk?
A: Premium rate bands provide for a positive correlation in premium rates with the relative health status or expected claims experience of the group. The concept also places both annual and aggregate caps on the amount that premium rates can be increased based on the presence of high-risk health conditions or adverse claims experience. Certainly, there are circumstances when a person's health condition is beyond his or her control; in addition, there are circumstances where it is within an

individual's control to make certain lifestyle choices. The annual and aggregate rating limits account for both scenarios.

Q: Under the NAIC model act, what are annual premium rate increases based on?
A: Rate increases are based on the change in an insurer's new business rate; any adjustments for changes in small employer case characteristics, such as changes in age and demographics and health status. In addition, SB 110 will cap any increases due to changes in the law to 25% for small businesses for the first 15 months the bill is in place.

Q: What protections are in place to protect access and affordability of coverage for high-risk groups?
A: The protections in place to prevent high-risk groups from being priced out of the market under SB 110 include:

- Guaranteed issue and renewability as required by federal law on all carriers in the small market group.
- The NAIC model has a 15 percent annual health status adjustment limit that means as part of a renewal, an insurer is limited to a 15 percent increase for the health status or claims experience of a group.
- As suggested by the NAIC model law, health status rating is limited to +/- 25%. Regardless of the severity of a group's health status, no group can be rated up more that 25% above a carrier's average premium rate.
- By attracting more carriers and more insurance products to the state, small businesses will now have the ability to "shop around" for insurance products that best meet the needs of their company and employees.
- Small group insurers must file their rates with the New Hampshire Department of Insurance, which has the ability to review the rates and determine if they are reasonable.
- Competition in the small group market will dictate the appropriateness of the rate if an insurer wants to remain competitive. Tying the highest rate to the lowest rate with the health status rating band forces insurers to actively compete for the low risk business yet keeps the highest rate within a reasonable range.

For more information, please contact Tom Murtagh at 603.652.7500 or Erik Taylor at 800.528.1181.

Attachment Q

SB 110 – Restoring Insurance Choice for Small Business

Promoting health insurance choice and affordability for New Hampshire's small businesses.

New Hampshire's small businesses and their employees will benefit from the provisions of the bill if passed because it:

✓ **Gives small businesses affordable health insurance solutions.** Current law has forced small businesses to face large health insurance premium increases that they can no longer afford in a slowing economy. By attracting more insurance carriers to New Hampshire and increasing the variety of insurance products available in the small group market, employers will have the ability to "shop around" for insurance products that meet their needs.

✓ **Preserves New Hampshire's commitment to guaranteed access to private health insurance for small businesses.**

✓ **Creates more competition in the health insurance industry by attracting health insurance carriers back to New Hampshire.** Many carriers stopped doing business in the state after 1995 because current law imposed restrictions that made it difficult to offer affordable health insurance coverage. While restoring competition and choice in the small group market will take time, insurance carriers have already committed to return to New Hampshire if SB 110 is enacted.

✓ **Provides small businesses with increased availability and access to modern insurance products** including HMO, PPO, Medical Savings Account (MSA) and Health Reimbursement Arrangement (HRA) plans. While these products are widely available in most states, New Hampshire's small businesses have not been able to buy these products due to the state's existing market laws.

✓ **Ensures guarantee issue insurance to small employers at reasonable costs** by requiring carriers to guarantee issue all plans and options, and establishing caps an insurer's underwriting ability at issue and renewal.

Key components of the bill:

✓ **Updates the state's definition of small group to 2 to 50 employees**, similar to laws in 37 states and DC, and consistent with federal law (HIPAA).

✓ **Enables insurance carriers to use rating bands that will encourage more competition for low-risk business and help manage the financial costs associated with high-risk groups.**

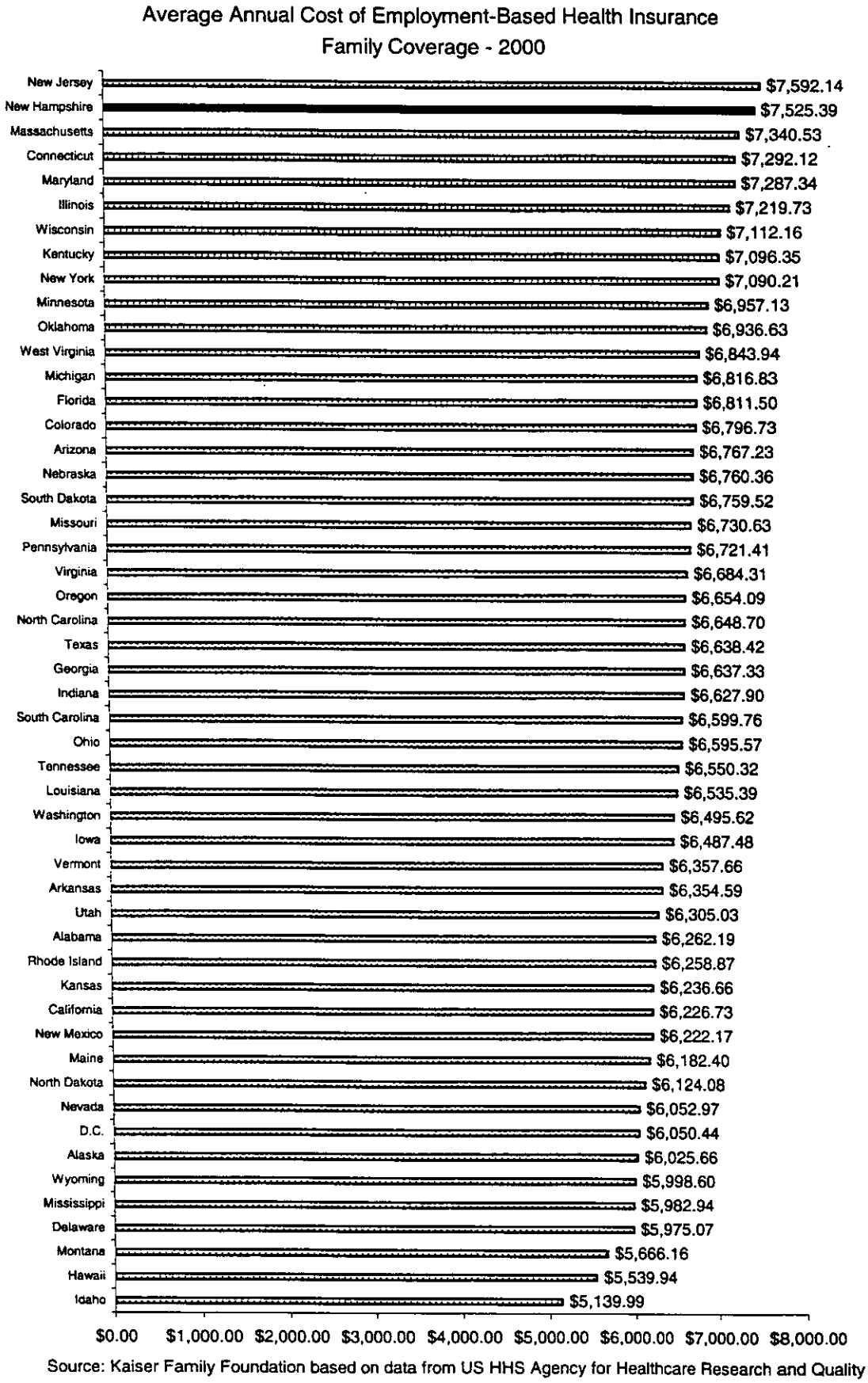
✓ **Introduces limited rating flexibility for small groups seeking insurance coverage based on health, age, industry and location.** The change would make New Hampshire consistent with laws in a majority of other states and Washington, D.C.

✓ **Caps renewal premium increases due to an employer's bad claims experience at 15 percent annually.**

✓ **Increases the age rating differential to 4:1**, which will result in lower insurance rates for younger families, matching New Hampshire's current individual law.

For more information, please contact Tom Murtagh at 603.652.7500 or Erik Taylor at 800.528.1181.

NH's small businesses pay some of the highest costs in the country for health insurance



Source: Kaiser Family Foundation based on data from US HHS Agency for Healthcare Research and Quality

Attachment K

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.

March 13, 2003

The Honorable Robert B. Flanders
The State Senate
Room 302
State House
Concord, NH 03301

Dear Senator Flanders:

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
CEO & President, Starmark
Trustmark Insurance Company

Attachment #5

Testimony of Tom Murtagh, Atlantic Plans, Milton, NH.

SB 110 – Small Group Health Insurance Coverage

SB 110 is an attempt to bring New Hampshire's laws pertaining to small and large employer health insurance in line with most other States.

No other State includes the 51 to 100 employee groups as a small employer. Allowing 50 to 100 employee groups to move to and from the partial self-funded market (that has no rates restrictions) when there healthy and have low claims to move to the small employer pool (that has rate caps) when they expect high claims is causing the small employer rates to be higher than they should be. NH small employers shouldn't have to subsidize large employers.

37 States and DC don't include 1 employee groups in their small employer definition. The small employer markets in the States that do, generally aren't working, they have no competition or choice of plans, examples are NH, VT and ME.

No carrier wants to write a group of 1, there are just to many ways for abuse.

Individuals or 1 employee groups can purchase a low cost high deductible plan in the individual market and when they get sick or have surgery pending just apply to the small employer market as a group of one. That currently is a sales pitch here in NH with the sales force of Mega Life Insurance Co., Mega markets a very high deductible plan and the pitch is "when you get sick just buy a better plan".

HIPAA (Health Insurance Portability and Accountability Act) eliminates the pre-existing condition clause for maternity coverage, therefore a young female sole proprietor could wait until the 8th. month of pregnancy to purchase health insurance, have full coverage for her pregnancy having only paid one months premium.

There's a misconception that if we change the definition of small employer to 2 to 50 the one employee groups will have no place to go.

Because SB 118 was passed by the NH Legislator and took effect July, 1, 2002, we now have 5 carriers issuing health insurance for individuals, the premiums are considerably less than the current employer market here in New Hampshire. Individuals that don't qualify are offered coverage under the NH High Risk Pool. (review chart)

Under HIPAA all health insurance policies are guaranteed renewable, your coverage can't be non-renewed. Also SB 110 limits the rate increases for all groups including groups of one to 25%, this provision will expire in 2005. I would encourage the Senate to strengthen the language in this provision to ensure that existing groups of one are protected.

SB 110 if passed will return carriers to New Hampshire give small employers more choice of plans including Medical Savings Account, MSA's where an employer can purchase a qualified high deductible plan and the employer or the employee can put away funds on a pre-tax basis to pay for health services, choice of plans will include the new Health Reimbursement Arrangements, HRA's where small employers can do some partial self-funding like large employers have been doing for years without the risk of a true partial-self-funded plan.

I would ask that you support this bill. SB 10 will improve the small employer insurance market in NH and will provide consumers with lower cost insurance options and greater choice.

Tom Mudash RE Attachment 10T

New Hampshire Maximum Annual Cost for Individuals and One Person Groups

Plan	Annual Insurance Premium Age 45	Max. OOP from Insurance	Maximum Cost Incl. Premium & OOP
Cigna Group Select 50	$3,530	$4,000	$7,530
Anthem BXBS Group	$3,832	$2,500	$5,332
Anthem BXBS Individual	$2,412	$4,000	$6,412
Fortis Individual	$3,422	$3,500	$6,922
NH Risk Pool	$2,712	$4,000	$6,712

Attachment 4

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.

A year ago when SB118 was being discussed John Alden made a commitment to return to the individual market. Last October we began selling individual insurance in NH. We have actually just announced a rate decrease on our most popular plans for May 1.

John Alden Insurance encourages you to pass SB 110 and we look forward to returning to New Hampshire with a full range of competitively priced insurance products for New Hampshire's small business community.

Thank you.

... from Liz Murphy

Attachment V

Enclosure Re: SB 110

Enclosure

Table 1: Number of Carriers, Largest Carrier, and Market Share Data for Small Group Health Insurance Carriers, by State

State	Number of licensed carriers	Largest carrier	Market share of largest carrier (percent)	Market share of five largest carriers (percent)	Rank of largest BCBS carrier	Market share of all BCBS carrier(s) (percent)
Alabama	10	BCBS of AL	87.4	93.8	1	87.4
Alaska	9	Premera Blue Cross	51.9	81.5	1	51.9
Arizona	53	United Healthcare of AZ, Inc.	24.5	66.9	2	20.8
California[a]	14[b]	Blue Cross of California[b]	NA	NA	1[b]	NA
Colorado	44	Employers Health	15.6	57.9	9	5.3
Connecticut[c]	47	Anthem BCBS of CT, Inc.	33.1	97.9	1	33.1
Delaware[a]	17	NA	NA	NA	NA	NA
District of Columbia[a]	9	NA	NA	NA	NA	NA
Florida	26	United Healthcare of FL, Inc.	21.6	64.6	2	26.9
Georgia	[d]	BCBS Health Care Plan of GA[d]	19.7[d]	47.3[d]	1[d]	28.3[d]
Hawaii[a]	4	NA	NA	NA	NA	NA
Idaho[a]	15	Regence Blue Shield	44.4	92.7	1	81.9
Illinois	36	NA	NA	NA	NA	NA
Indiana	77	Anthem Insurance Company	18.5	51.1	1	18.5
Iowa	54	Wellmark, Inc.[e]	46.5[e]	76.7[e]	1[e]	52.8[e]
Kansas[a]	35	BCBS of KS, Inc.[f]	NA	NA	1[f]	NA
Kentucky	10	Anthem	43.7	89.2	1	43.7
Maine	13	Aetna US Healthcare	45.6	90.9	2	39.1
Maryland	18	CareFirst, Inc.	48.2	95.3	1	48.2
Massachusetts	24	HMO Blue	30.6	79.0	1	37.1
Michigan[g]	64	BCBS of MI	63.2	84.8	1	79.1
Minnesota	20	BCBSM, Inc.[h]	42.0[h]	87.7[h]	1[h]	49.6[h]
Missouri[a]	47	Healthy Alliance Life Ins. Company	18.9	51.8	1	32.2
Montana	[f]	BCBS of MT	40.8	78.0	1	40.8
Nebraska[a]	30	NA	NA	NA	NA	NA
New Hampshire[a]	9	Healthsource NH	40.0	75.2[j]	2	35.2
New Jersey[k]	22	Horizon BCBS of NJ	30.1	84.4	1	46.0
New York	34[l]	Oxford[m]	18.5[m]	57.2[m]	2[m]	26.5[m]
North Carolina	37	BCBS of NC	26.6	67.5	1	26.6
North Dakota	12	Noridian/BCBS	88.8	95.7	1	88.8
Ohio[c]	70	Anthem BCBS	32.6	66.4	1	32.6
Oklahoma[a]	64	Group Health Services of OK[f]	NA	NA	1[f]	NA
Oregon[a]	13	Lifewise, A Premera Health Plan	22.7	73.7	3	23.1
South Carolina	54	PHP	31.4	72.8	2	25.4
South Dakota[a]	15	Wellmark BCBS of SD	28.6	60.3	1	28.6
Tennessee	59	BCBS of TN[n]	54.7[n]	81.1[n]	1[n]	61.4[n]

02

P13

Enclosure

State	Number of licensed carriers	Largest carrier	Market share of largest carrier (percent)	Market share of five largest carriers (percent)	Rank of largest BCBS carrier	Market share of all BCBS carrier(s) (percent)
Texas	59[a]	Employers Health Insurance Company	13.9	36.1	2	6.9
Utah	44	IHC Health Plans, Inc.	29.1	83.5	2	22.7
Vermont	6	MVP Health Plan	45.8	98.6	5	2.6
Virginia[o]	56	NA	NA	NA	NA	NA
Washington[p]	[q]	Premera Blue Cross	40.5	86.5	1	78.8
Wisconsin	64	United Healthcare of WI[h]	16.1[h]	45.4[h]	2[h]	9.1[h]
Wyoming	14	BCBS of WY[n]	38.5[n]	55.1[n]	1[n]	38.5[n]

NA = not available.

Notes: Reported data are for December 2000 unless otherwise noted.

Ranking and market share data are based on the number of covered lives unless otherwise noted.

Three states did not respond to the survey: Nevada, New Mexico, and Rhode Island. In addition, five states responded but did not provide data on small group carriers or on market share: Arkansas, Louisiana, Mississippi, Pennsylvania, and West Virginia.

[a]Data are for December 2001.
[b]Data only include carriers regulated by the California Department of Managed Health Care.
[c]Data are for December 1999.
[d]Georgia reported that there are no standard reporting sources on the number of carriers and the total number of covered lives in the small group market, but estimated the number of carriers at about 100 and estimated the total number of covered lives to be 500,000. We used the estimated number of covered lives to calculate rankings and market share.
[e]Ranking and market share calculation are based on the number of covered small employer groups.
[f]Ranking is based on gross premiums.
[g]Data are for March 2001.
[h]Ranking and market share calculation are based on gross premiums.
[i]A Montana official estimated 10 or fewer carriers had plans that were approved for the small group market.
[j]New Hampshire did not report data for the five largest carriers. Market share calculation is based on the data reported for the two largest carriers.
[k]Data are for September 2001.
[l]Data are for January 2002.
[m]Data are for January 2001.
[n]Ranking and market share calculation are based on the number of covered employees.
[o]Data are for November 2001.
[p]Data are for various time periods in 2000 and 2001.
[q]Washington reported that 16 state-based carriers and an unknown number of out-of-state carriers offer health insurance in the small group market.

Source: GAO survey of state insurance regulators.

(290170)

(p23)

Attachment #10

My name is CLH and I have been a sole prop since July, 1986. My business is insurance and financial services to individuals who have no group benefits as well as to small business owners who are looking for health and ancillary benefits for themselves or for their employees. I am located in Laconia and focus essentially on the Lakes Region.

I represent most all insurance companies that provide coverage to these individuals and have obviously been in the midst of tumultuous changes over the past decade as companies have come and gone.

From my experience the typical small business owner is unindated w/ paperwork and taxes in an effort to earn a living. As some of you may be aware, full deductibility of health insurance is not available to ~~sole~~ unincorporated business owner proprietors. Whether they have employees or not, their personal insurance is currently on an upward sliding scale which took years of legislative effort in Washington. As a result, in another few years we as sole props will be given equal parity to our peers when it comes to premium deductions. We also pay our fair shared the business Profits tax, irrespective of having no one other than ourselves creating that income That being said, I also know of no difference w/my being a sole proprietor or a business w/a host of employees when it comes to the business profits tax. I pay equal to any business irrespective of the fact that I am alone.

With the introduction of this bill, which has several components to it, I look to address the one area that brings me to my feet in front of this committee. No less than 30 people w/in my client base of small business owners would stand by my side today and ask that you not allow us to be the scapegoat for the rising costs in health care as well as the declining number of companies willing to do business in this State.

In a health care forum held last week, I listened to stories of how easy it is for one to become a business by paying a $50 fee to the State making one eligible to purchase group insurance. I also heard how easy it is for individuals to switch from catastrophic individual insurance to group benefits when pregnancy or any other looming large claim manifests itself. While both of those issues are indeed factual, I find it highly inflammatory on the basis of all the facts that are equally true.

NH is a proud state w/a proud motto. The typical small town community is far more prevalent than a robust metropolitan area. It is the small business owner that makes the wheel turn in this state – the classic blue-

collar worker who builds homes, sheetrocks, paints, landscapes; the real estate agent who is working 80 hours week keeping up w/this low interest environment, the graphic arts designer who is hired as a 1099 consultant – the list goes on. These are the people who not only compete against large companies but they are the ones who have to work twice as hard to stay in business. Now, SB 110 wants to blame this group as one of the main reasons we have so little competition and for the high claims loss ratio being experienced.

There is no perfect business model that I am aware of. Someone can always finds a loophole to gain the advantage. But, this hard-working, creative and dedicated workforce of sole proprietors is not the group to be targeting. Many of these businessowners are not the young, cherished crowd of the actuarial department. No, we are the more mature group who have worked several decades to be the successful enterpreneurs necessary to stay in business. Along the way prescriptions become part of our lives, but individuals applying for catastrophic plans outside the group market are cherry-picked to an embarrassing degree. And I have documentation showing how slight a preexisting condition can warrant denial and a sentence to the high-risk pool.

I respectfully request that you consider not throwing away the baby w/the bath water. It is you the NH legislature that allowed for groups of sole proprietors working for themselves to be included in the group health market. Please don't take that away from us and vote against SB 110.

SB 118 may have brought back additional plans

I encourage you to consider this bill as it is written and that an amendment to give the one-person group a 12-18 mo. timeframe is simply not good enough.

Attachment X

New Hampshire Special Ballot

SHOULD NEW HAMPSHIRE ESTABLISH A "RATING BAND" FOR SMALL BUSINESS HEALTH INSURANCE PREMIUMS THAT LIMITS HOW MUCH INSURANCE COMPANIES CAN INCREASE PREMIUMS FROM YEAR-TO-YEAR?

75% YES 14% NO 11% UNDECIDED

BACKGROUND: When the New Hampshire Legislature last overhauled health insurance laws, "community rating" was used to determine how health insurance rates were set. Under community rating health insurance companies must charge the same rate for every business regardless of the experience of employees of each individual business. Accordingly, businesses with good (few claims) health insurance experience are charged the same rates as business with very bad (numerous claims) health insurance experience. Rating bands permit insurance companies to take the experience of a business into account but provide protection from huge premium increases by limiting the amount a premium can increase from year-to-year.

New Hampshire small businesses have seen a steady rise in their health insurance premiums over the last several years. At the same time, most health insurance companies in New Hampshire have stopped offering policies altogether, citing their inability to offer a competitive policy. These factors have created a severe situation for small business attempting to purchase health insurance.

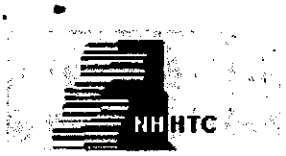
PROPONENTS of a establishing a "rating band" for health insurance premiums argue that it will permit insurance companies to take into account the experience of a business in establishing premiums and thus allow businesses with good experience to benefit by getting lower, more affordable health insurance premiums. At the same time, rating bands protect small businesses from huge premium increases by placing statutory limits on how much premiums can increase from year-to-year. Furthermore, rating bands will attract health insurance companies back into New Hampshire by establishing a more competitive market for small business health insurance. As a result, small businesses will have the opportunity to purchase affordable health insurance once again.

OPPONENTS of the rating band approach argue that it is unfair to rate individuals based on experience. Since health insurance is a basic need for everyone it is unjust to penalize someone for being sick. Everyone should be charged the same rate regardless of his or her health condition. Furthermore, the limits on premium increases in the rating band approach still permit insurance companies to raise premiums so a business with just one sick employee could experience premium increases.

Please return this completed ballot to the NFIB Northeast Region office by faxing it to 717- 232-4098 by Friday, March 7, 2003.

Thank you for your prompt attention to this matter.
Your valuable input is appreciated!

Attachment Y



Testimony to the Senate Insurance Committee
Regarding Senate Bill 110
March 18, 2002

For the record my name is Andy Dillman and I live in Hudson, N.H. I am here today representing the New Hampshire High Tech Council. The NHHTC is comprised of more than 250 businesses that primarily focus in the high tech arena.

New Hampshire is a great place for high tech firms to locate. We have a highly educated work force that is filled with an entrepreneurial spirit. The legislature and governmental leaders have created many advantages for our members to grow their businesses here in New Hampshire.

Unfortunately, the cost of health insurance is forcing many small businesses into an uncompetitive position. We are one of the healthiest states in the union and yet we have one of the highest costs in the nation. If rates do not become more competitive we will lose the NH advantages; and be forced to choose between dropping health coverage for our employees or shipping more jobs abroad.

Free and fair competition unteathered by heavy legislative requirements has made our state competitive in the high tech marketplace. The Achilles heel of our growth is the cost of health insurance. We see Senate Bill 110 as spawning competition in a marketplace where we are a breath or two away from a monopoly.

As the bill progresses through the legislature we will be happy to provide this committee with more business owners who are thirsty for a competitive health insurance marketplace.

Attachment 2

Testimony to be delivered before the NH Senate Insurance 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, even the bill's supporters have indicated that these new calculations could have profound negative effects for the North Country.

Almost half of Coos County employers are currently 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. Currently 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:

- 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 and hypertension 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 -- safety net providers that provide 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.

Attachment AA

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 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 – More insurers will come into the state.
The insurers do not control the underlying costs of healthcare. The source of the costs is with the providers. 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.

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.

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.

Separating out employer groups of one will discourage entrepreneurs and preclude individuals from starting businesses in New Hampshire. Due to the downturn in the economy, a significant number of individuals have started their own businesses. However, requiring a start-up to purchase insurance in the individual market will potentially make the cost of the coverage prohibitive.

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 is the New Hampshire advantage.**

Attachment BB

03/18/03

Re: SB110

I believe this bill is flawed and should be defeated.

I am a 26 year veteran of the life and health insurance industry. I am a past president of NAIFA and I ran my own insurance office for 16 years and am in the process of buying a 10 person insurance office. I state these facts to show that I have some experience in health insurance as an agent, consumer and employer.

All insurance rates are subject to the following formula:

LOSSES + EXPENSES-INTEREST= RATE

This has always been true and it will never change. Interest rates are down, claims are up and expenses are stable, though one could make a case that they will go up when we start doing limited medical underwriting with the return of health questions. This means whether we like it or not, or unless the insurance company wants to go bankrupt, that rates have to go up. This formula is like the seasons you make not like them but they will show up and cycle through. This bill does nothing to address losses driven by usage and cost of services.

The same rational for this bill was used to explain that we needed underwriting in the individual market so more companies and competition would appear. Well, we are now at the same number of companies that we had before the passage of the individual market reform. One came in and one left. As an aside it has been noted by many health insurance agents that contrary to what was said by the companies, the underwriting is taking a long time for issue and it is starting to appear as nit picky as it was in the past. So we sacrifice our sole proprietors and one man groups for the wish and a prayer of maybe one more company entering the market.

Health insurance does not work like any other insurance market place, unlike home insurance where all uninsured claims are uninsured and not cost shifted to others with insurance policies., in health insurance if I were uninsured I would have services and the costs associated with those services. These costs would not leave the system but would be shared by all participants in the system. Thus the goal of the system should be to make it as easy as possible for all to get a policy and have some insurance to limit cost shifting.

Where is the proof that the one person groups are showing higher claims than the larger groups? This proof is needed to see if the single person groups are helping or hurting the premium mix.

Large corporations, Medicare, and Medicaid all are facing 15% plus or minus increases in cost. This would indicate the problem is not just a competition issue.

The last time we had more than 2 companies in the group market we bankrupted one, almost bankrupted one, and didn't reduce rates when looked at over a three year period. My opinion no new company can afford the losses needed to stay in the market long enough to build a critical mass.

Just a couple of quick points you might want to think about when you explain to your constituents why you voted for this bill.

We are the only state that has no sales tax or income tax. That is our advantage. Why doesn't our uniqueness work as one of one (1-100) or one of 13 (1-50) in health insurance in states that allow single person groups.

Our sole proprietors are the backbone of this state why penalize them. Why penalize those sole proprietors who currently have taken responsibility for their health expenses by forcing them into the individual market where they might be forced into the pool by health problems that happened after they started the original group policy.

We have a very high percentage of insureds. Why keep messing with a system that allows people to get insured. This, plus our being one of the healthier states, means we probably use a lot of health care.

Sole proprietors move on to hire employees and if they have group policies they will add employees. A sole proprietor, with an individual policy, will just keep the individual policy and let the employee go without coverage.

The industry weighting will affect white collar groups more than blue collar groups.

We already have high, low, and in between deductible plans. We have HMO's and Point of Service plans. WE have plans with chiropractic benefits and without.

Could it be that POGO was right? "The problem is us" Every major study of health care both from cost and performance has stated the following: We want Cadillac coverage for Yugo prices.

Lastly a story about our agency. We employ 10 people, 2 are over 65. We also allow 3 employees to buy into our health plan as a thanks for their service and dedication. When you rate my group with an age factor I will seriously have to look at why we should continue to offer the buy in for the retirees and the 2 employees due to retire soon when they retire. The reality is we will probably continue to offer it but it is certainly a disincentive. I will not be the only small employer asking these questions. Do you not think that an employer knowing about the age weighting will not look closely at his hiring decisions and its potential costs?

Vote this bill down and see what happens in the individual market in the next five years (the time needed for it to reach equilibrium and see how stable its rate and pool population is.) then come back and see what worked and what did not.

Dick White
Clyde B Foss Agency
PO Box 159
Moultonboro NH 03254

Chandler, Merideth

From: Duncan, Susan
Sent: Monday, March 24, 2003 4:17 PM
To: Williams, Chris; Chandler, Merideth
Subject: FW: SB110

FYI Susan

-----Original Message-----
From: CBMEYE@aol.com [mailto:CBMEYE@aol.com]
Sent: Monday, March 24, 2003 2:32 PM
To: robert.flanders@leg.state.nh.us; susan.duncan@leg.state.nh.us
Cc: CBMEYE@aol.com
Subject: SB110

Dear Senator Flanders, Insurance Committee Chair

RE: Senate Bill 110

I understand that Senate Bill 100 may come to a vote on Tuesday, March 25th. I would like to share with you a few thoughts before there is a vote on this bill.

I understand this is a controversial bill. There are several components to it that perhaps in its entirety cause that controversy. I wanted to speak in front of the committee at last week's hearing, but I had to work at that time.

Earlier this month, I sent Senator Iris Estabrook, who represents my area, a letter expressing my concerns regarding this bill. The following items remain my concerns regarding this bill.

I am a self-employed individual working in this state, thus a very small but viable business. I have no employees, but am still able to obtain health insurance coverage at group rates. Yes, it is very costly, but at least it is available. Of my seven small business clients, four of them work as sole proprietors as well. One has health insurance coverage with her spouse's employer; one cannot afford coverage and because she is so young, feels she can go without; and two pay health insurance premiums themselves. By passing this bill, with the group size change, you are telling us we will no longer be eligible for health insurance at group rates as viable small businesses.

Perhaps alternatives could be considered when defining a small group. For example, 1 to 20 members is a small group, 21-50 members is a medium group, and more than 50 is part of the large group market. This still allows small business owners in my situation eligibility for coverage.

This bill also leaves open the opportunity for much age discrimination in the hiring process. I am in my mid-40s. If I were forced to return to a full-time job with an employer just for the health benefits, especially in a "small business", my age would not be in my favor. Younger groups would rule. Even if us older workers are generally quality, dependable employees, I believe employers who really want to keep their claims experience low will further discriminate against us. This discrimination already seems rampant in the business world and this bill would only make matters worse. Community rating may not be working like some would like it to in this state. However, reverting to "experience rating" I believe would create a larger disaster and put those individuals who really need health insurance coverage totally out of the market. What happens then - we go without health insurance, can't afford to pay the enormous medical bills that can result from everyday medical situations, the hospitals and doctors end up paying for it, and back to us with higher medical costs and health insurance premiums.

With regard to health insurance coverage, I would like to be a part of a favorable solution to this pervasive American and New Hampshire problem. This solution would hopefully benefit all involved, including self-employed small business owners and small businesses in general. After all, as American workers continue to get laid-off from their larger employers, we are forced to turn to our own resources to support out families and ourselves. One thing we still need is health insurance coverage.

Thank you for your time reviewing my concerns. I wish you well with your efforts on behalf of New Hampshire citizens.

Sincerely,

Claire Blaisdell
PO Box 388
Dover NH 03821-0388

Date: March 17, 2003
To: Senate Insurance Committee
From: Mary E. Ruppert Mary E. Ruppert
Lyman NH
mruppert@ncia.net

Dear Chairman Flanders and Members of the Committee,

As a sole proprietor of a small business, I am very concerned about the impact SB 110 will have on my ability, and the ability of other small business owners in the North Country, to purchase affordable health insurance.

I am particularly concerned about two aspects of SB 110 – the change to the definition of small group and the proposal to charge premiums based on which Health Care Service Area (HSA) that people live in.

SB 110 proposes to change the definition on small group to eliminate sole proprietorships from the small group market. The sponsors of the bill state that sole proprietors can purchase insurance through the individual market. However, the health insurance plans available from the small group market and the plans available in the individual market are not comparable. The plans available to individuals have higher out of pocket expenses in the form of significantly higher plan deductibles. So, while it might appear that there is a savings in premium, any difference is negated by significantly higher out of pocket expenses.

Of particular concern is the underwriting involved in the individual market. This underwriting policy (which may vary from carrier to carrier) disallows coverage in the individual market for a long list of preexisting conditions. As a breast cancer survivor of more than 5 years, if I am denied coverage in the individual market because of underwriting, the only option left for me to obtain health insurance would be the NH Health Plan (the High Risk Pool). While NH has done a good job designing a high-risk pool product, it remains an issue that the out of pocket costs are many times higher than the out of pocket expenses available in plans through the individual market and many, many times higher than the small group market. In addition, the plan maximums in the NH Health Plan are one-half of what is available in either the individual

or the small group market. (Please reference http://www.nhhealthplan.org/ for more information. Please note that the Deductible and Plan Maximum Tables are not posted on this site – these may be obtained from a health insurance broker or by calling the NH Health Plan. I could also send you copies if you would like.)

I understand the proposal in SB 110 to charge premiums based on geographic location is driven by the higher costs of health care on the Seacoast and in the North Country. As an informed consumer, I know the cost of the health care I am purchasing. I know that quality health care may be less expensive at facilities outside of the local "HSA". I also know that choosing to purchase health care at an expensive facility will increase my own health care costs. As a responsible consumer concerned about quality as well as cost, I chose to travel outside of the designated local "HSA" for almost all of my health care. I find the arbitrary grouping of towns into "HSAs" probably more useful as a tool for hospitals to assess their market share than, at lease for me, as an indicator of my health care consumer behaviors. Thus, I object strenuously to the discriminatory proposal to charge higher premiums based solely on geographic location.

It would seem that SB 110 is likely to affect many small businesses in the North Country. The industries listed by Anthem Blue Cross and Blue Shield as most "risky" to insure (and thus subject to higher premiums) include the tourism staples of lodging and food service. Also included are health care providers, auto services, social services and lumber operations. All of these are important parts of the North Country economy.

Thank you for your time and attention.

SB 110 Oversight Committee
Interim Report
August 4, 2004

The Department recognizes the Committee's need for information. These charts have been developed to assist you in your work and to provide a better understanding of New Hampshire's health insurance markets. The Department cautions that this data is incomplete and does not provide sufficient basis for reaching firm conclusions regarding the impact of SB 110 on the small group market.

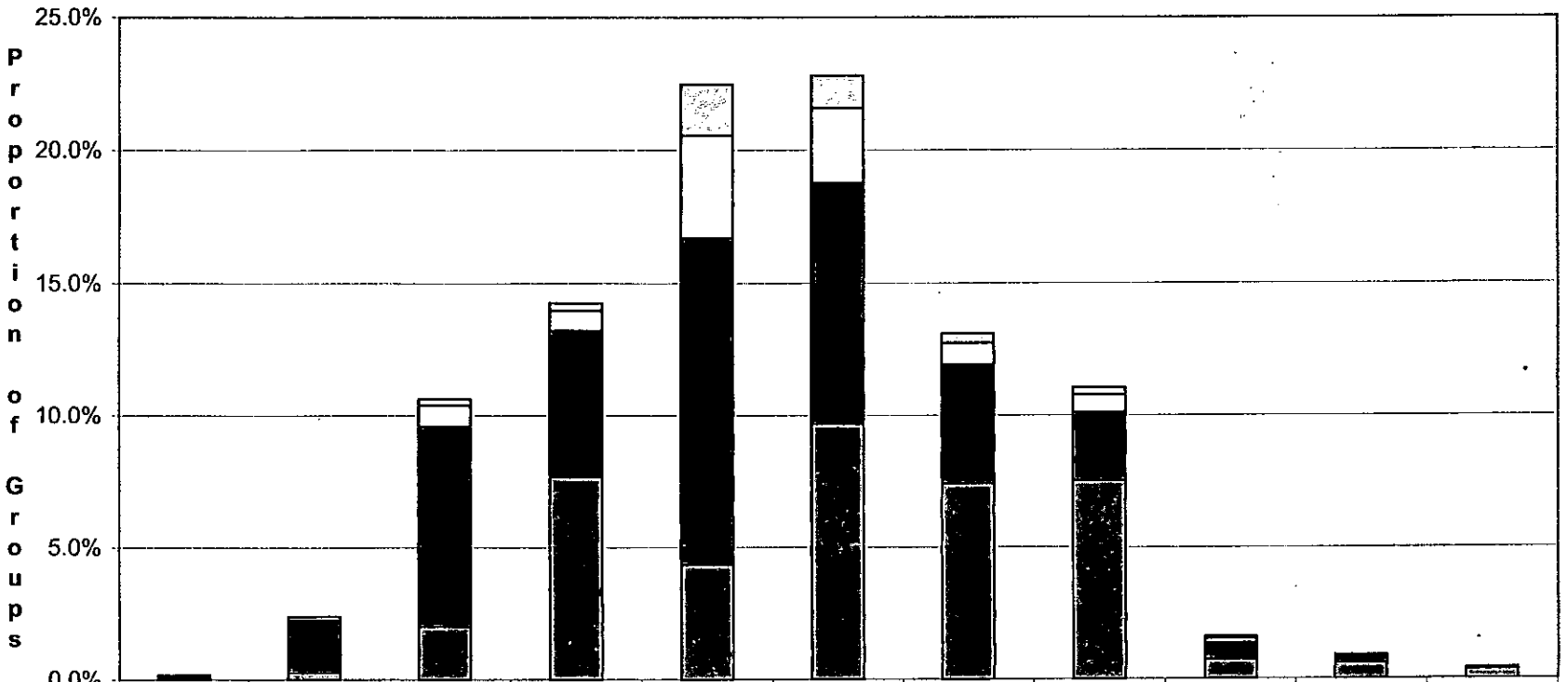
The Department was not able to collect information from each and every carrier. These charts are based on information provided by the HMO's.

The Department is still analyzing the information provided. Some of the extreme outliers may be attributable to errors in reporting. The Department is conducting further review of the data.

The Department modeled what legislators might anticipate the variation in premium rates would be upon the implementation of SB110. The actual variation in first quarter renewals is presented on a PEPM basis, Per Employee Per Month, and on a PMPM basis, Per Member Per Month. Generally, there seems to be slightly more variation in rates than the Department model predicted.

Information on premiums, claims and income, might suggest that the industry was moving from a soft market to a hard market beginning in 2000 and that the hard market may be nearing its apex today. Some groups do appear to be moving from the self-funded market to the fully insured market.

Rate Changes Anticipated the First Year Small Group Reform is Effective
Assumed Trend at 12.5%

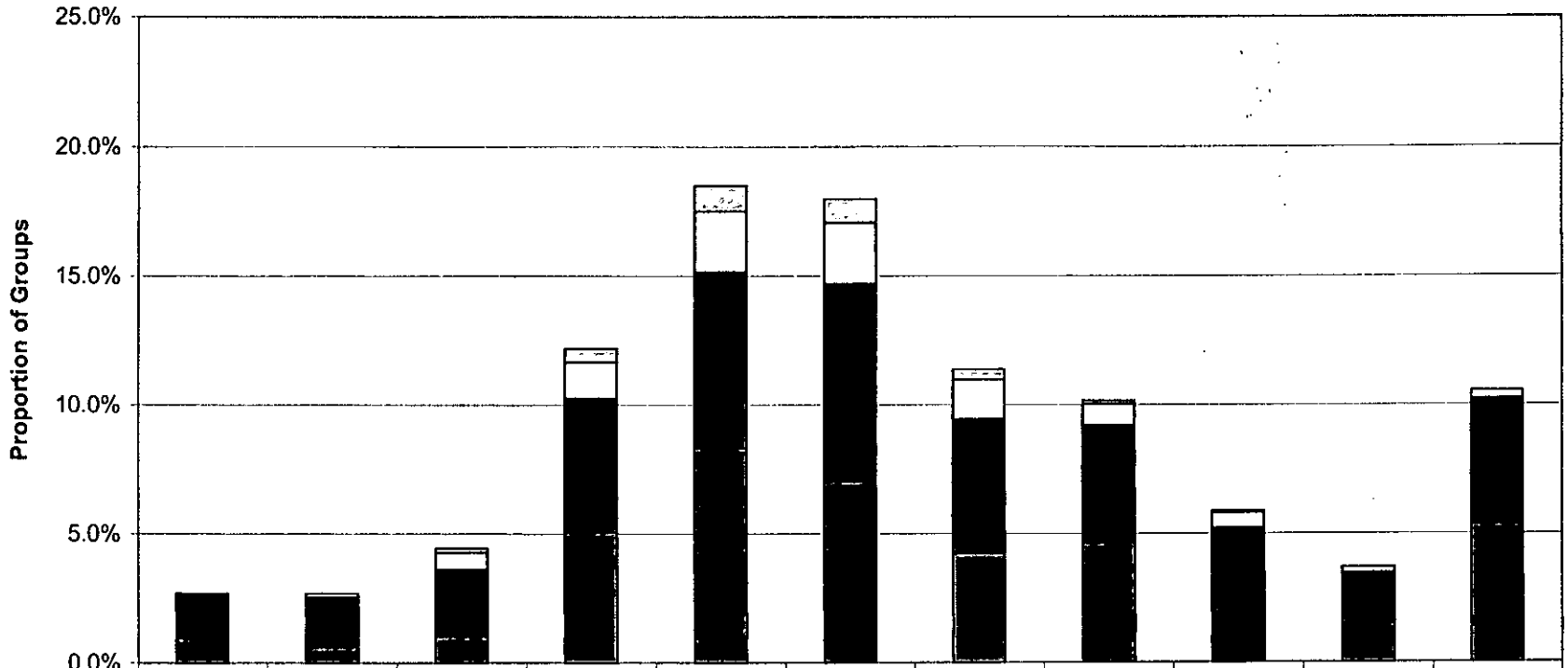


	-30%	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70%
25-49	0.0%	0.0%	0.2%	0.3%	1.9%	1.2%	0.4%	0.3%	0.1%	0.0%	0.0%
10-24	0.0%	0.1%	0.8%	0.8%	3.9%	2.8%	0.8%	0.7%	0.2%	0.1%	0.0%
2-9	0.1%	2.0%	7.5%	5.6%	12.3%	9.1%	4.5%	2.6%	0.6%	0.2%	0.1%
1	0.1%	0.3%	2.0%	7.7%	4.3%	9.7%	7.4%	7.5%	0.7%	0.6%	0.3%

Rate Change
min -37.7% max 100.1%

NH Insurance Department
April 15, 2003

PEPM Analysis
1st Quarter Renewals



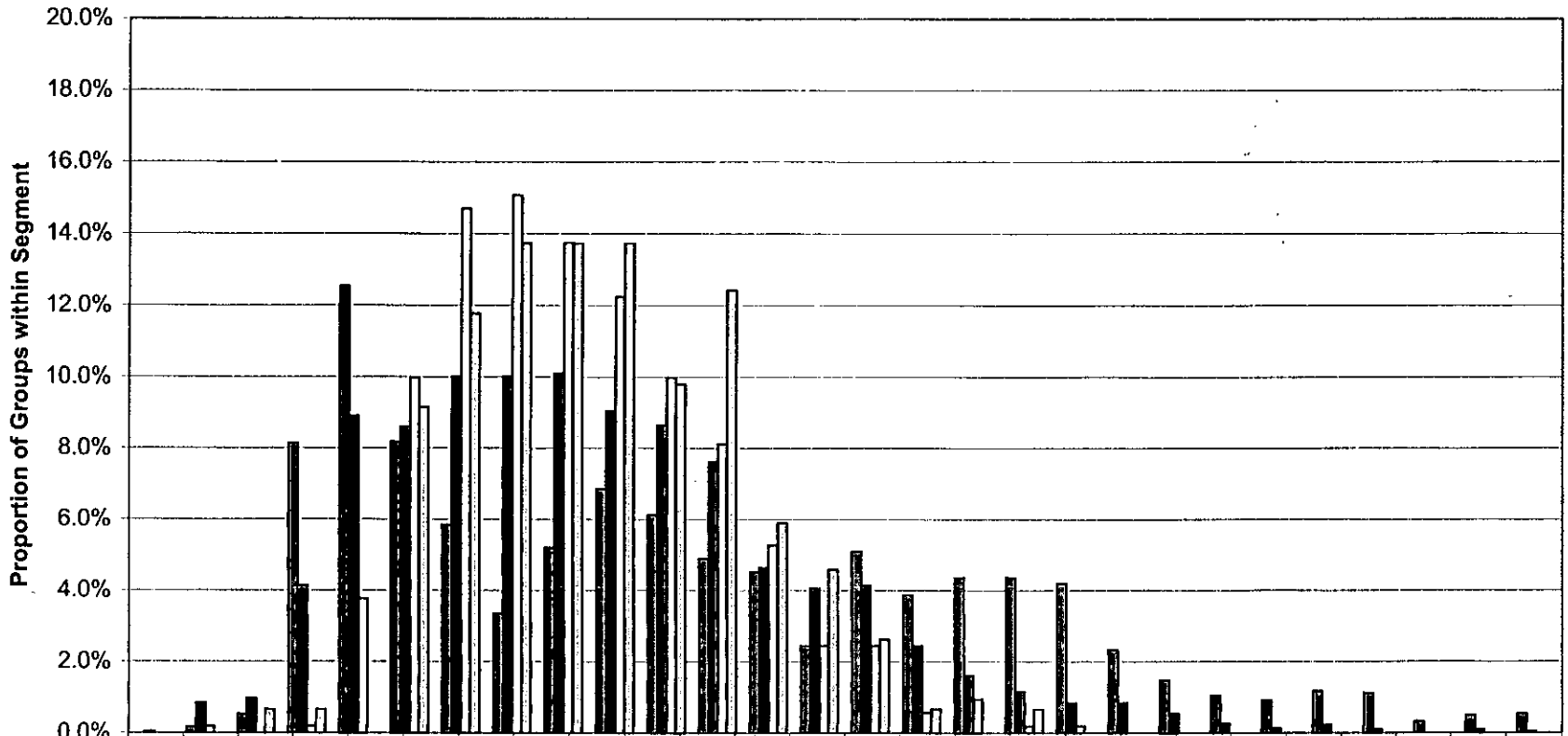
	-30% +	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70% +
25-49	0.0%	0.0%	0.2%	0.5%	1.0%	0.9%	0.4%	0.1%	0.1%	0.0%	0.0%
10-24	0.1%	0.2%	0.7%	1.4%	2.3%	2.4%	1.5%	0.8%	0.6%	0.2%	0.3%
2-9	1.7%	1.9%	2.6%	5.2%	6.8%	7.7%	5.2%	4.6%	3.1%	2.0%	4.9%
1	0.9%	0.6%	1.0%	5.1%	8.3%	7.0%	4.2%	4.6%	2.1%	1.5%	5.3%

Rate Change
min -90%, max 650%

NH Insurance Department
July 2004
Source: Special Data Request to Carriers

Initial Distribution: SB110 Oversight Committee

2003 PEPM Relative to Median (485) - 1st Quarter Renewals



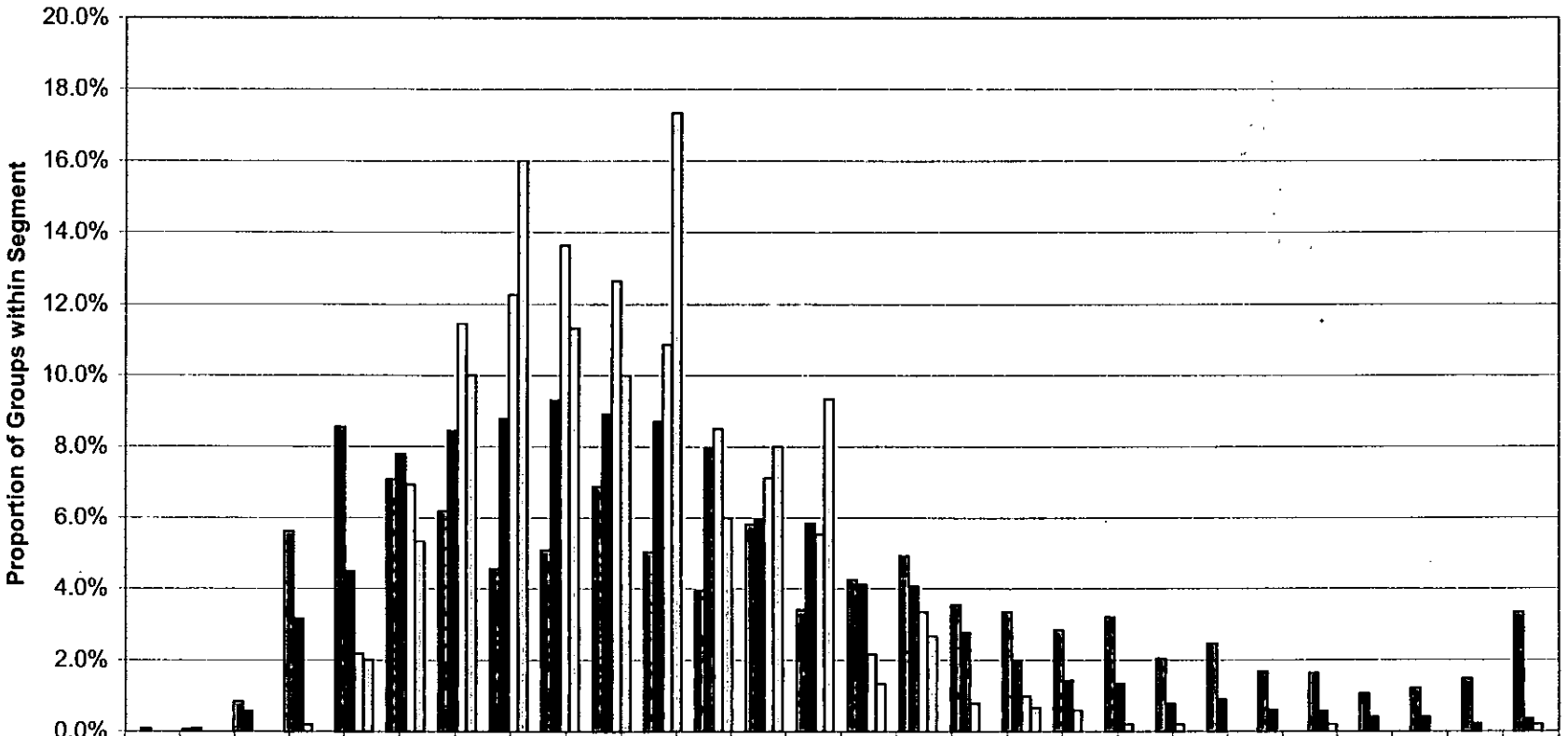
	85	135	185	235	285	335	385	485	535	585	635	685	735	785	835	885	935	985	1035	1085	1185	1235	1285	1335	1385	1435+
1	0.0%	0.2%	0.5%	8.1%	12.5%	8.2%	5.8%	5.2%	6.9%	6.1%	4.9%	4.5%	2.4%	5.1%	3.9%	4.4%	4.4%	4.2%	2.3%	1.5%	0.9%	1.2%	1.1%	0.3%	0.5%	0.5%
2-9	0.0%	0.8%	1.0%	4.1%	8.9%	8.6%	10.0%	10.1%	9.0%	8.6%	7.6%	4.6%	4.0%	4.1%	2.4%	1.6%	1.2%	0.8%	0.8%	0.5%	0.1%	0.2%	0.1%	0.0%	0.1%	0.0%
10-24	0.0%	0.2%	0.0%	0.2%	3.8%	10.0%	14.7%	13.7%	12.2%	10.0%	8.1%	5.3%	2.4%	2.4%	0.6%	0.9%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.7%	0.7%	0.0%	9.2%	11.8%	13.7%	13.7%	9.8%	12.4%	5.9%	4.6%	2.6%	0.7%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PEPM

NH Insurance Department
July 2004
Source: Special Data Request to Carriers

Initial Distribution: SB110 Oversight Committee

2004 PEPM Relative to Median (535) - 1st Quarter Renewals



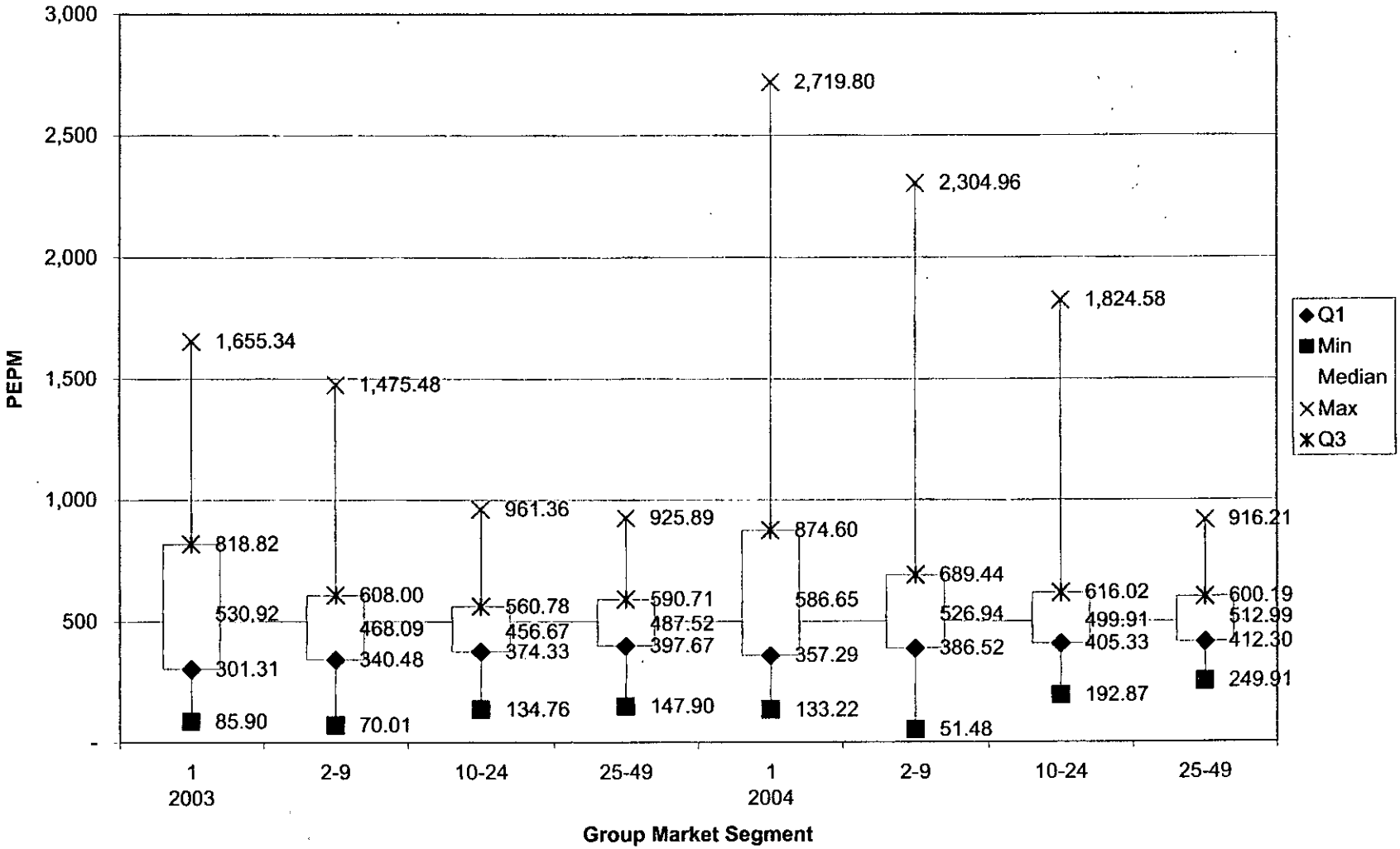
	85	135	185	235	285	335	385	485	535	585	635	685	735	785	835	885	935	985	1035	1085	1185	1235	1285	1335	1385	1435+
1	0.0%	0.1%	0.8%	5.6%	8.5%	7.1%	6.2%	5.1%	6.9%	5.0%	3.9%	5.8%	3.4%	4.2%	4.9%	3.6%	3.4%	2.8%	3.2%	2.0%	1.7%	1.6%	1.0%	1.2%	1.5%	3.4%
2-9	0.1%	0.1%	0.6%	3.2%	4.5%	7.8%	8.4%	9.3%	8.9%	8.7%	8.0%	6.0%	5.8%	4.1%	4.1%	2.8%	2.0%	1.4%	1.3%	0.8%	0.6%	0.6%	0.4%	0.4%	0.2%	0.3%
10-24	0.0%	0.0%	0.0%	0.2%	2.2%	6.9%	11.5%	13.6%	12.6%	10.9%	8.5%	7.1%	5.5%	2.2%	3.4%	0.8%	1.0%	0.6%	0.2%	0.2%	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%
25-49	0.0%	0.0%	0.0%	0.0%	2.0%	5.3%	10.0%	11.3%	10.0%	17.3%	6.0%	8.0%	9.3%	1.3%	2.7%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PEPM

NH Insurance Department
July 2004
Source: Special Data Request to Carriers

Initial Distribution: SB110 Oversight Committee

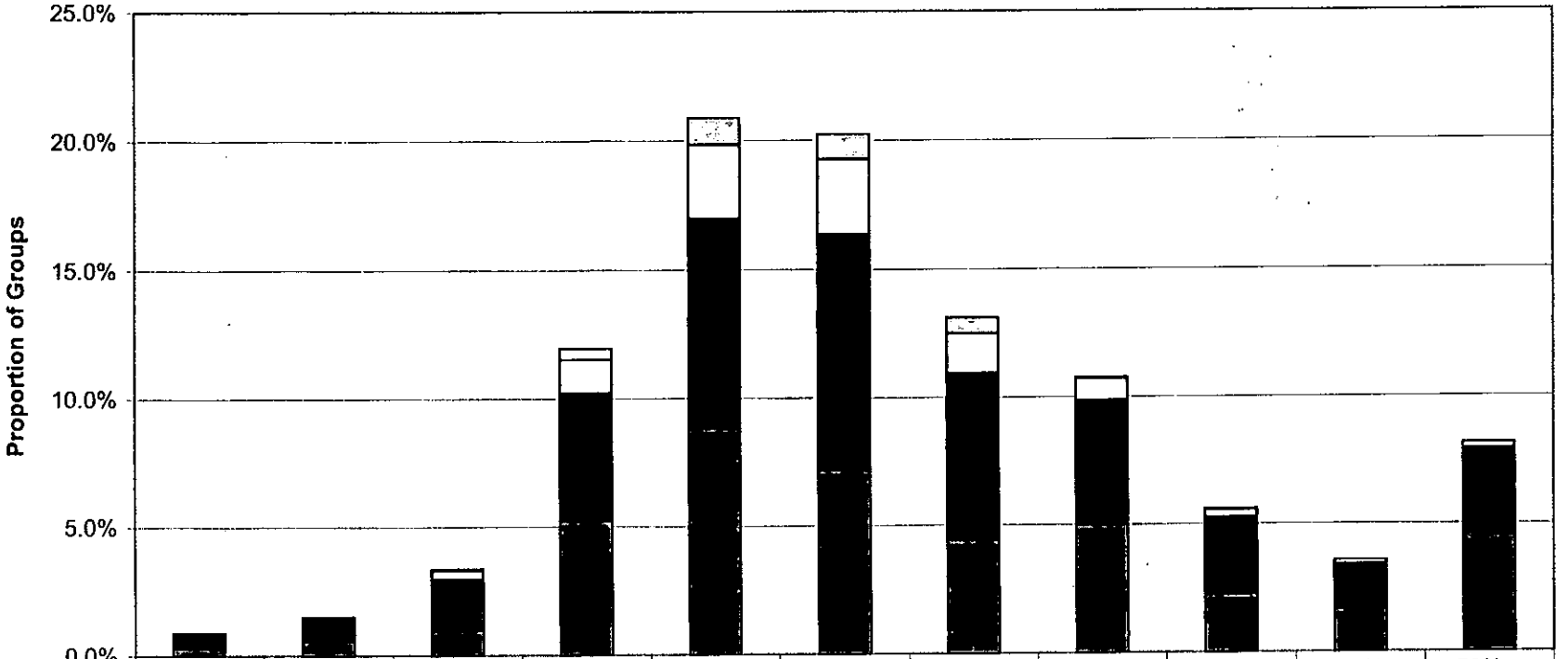
PEPM Box Plot - 1st Quarter Renewals



NH Insurance Department
July 2004
Source: Special Data Request to Carriers

Initial Distribution: SB110 Oversight Committee

PMPM Analysis
1st Quarter Renewals



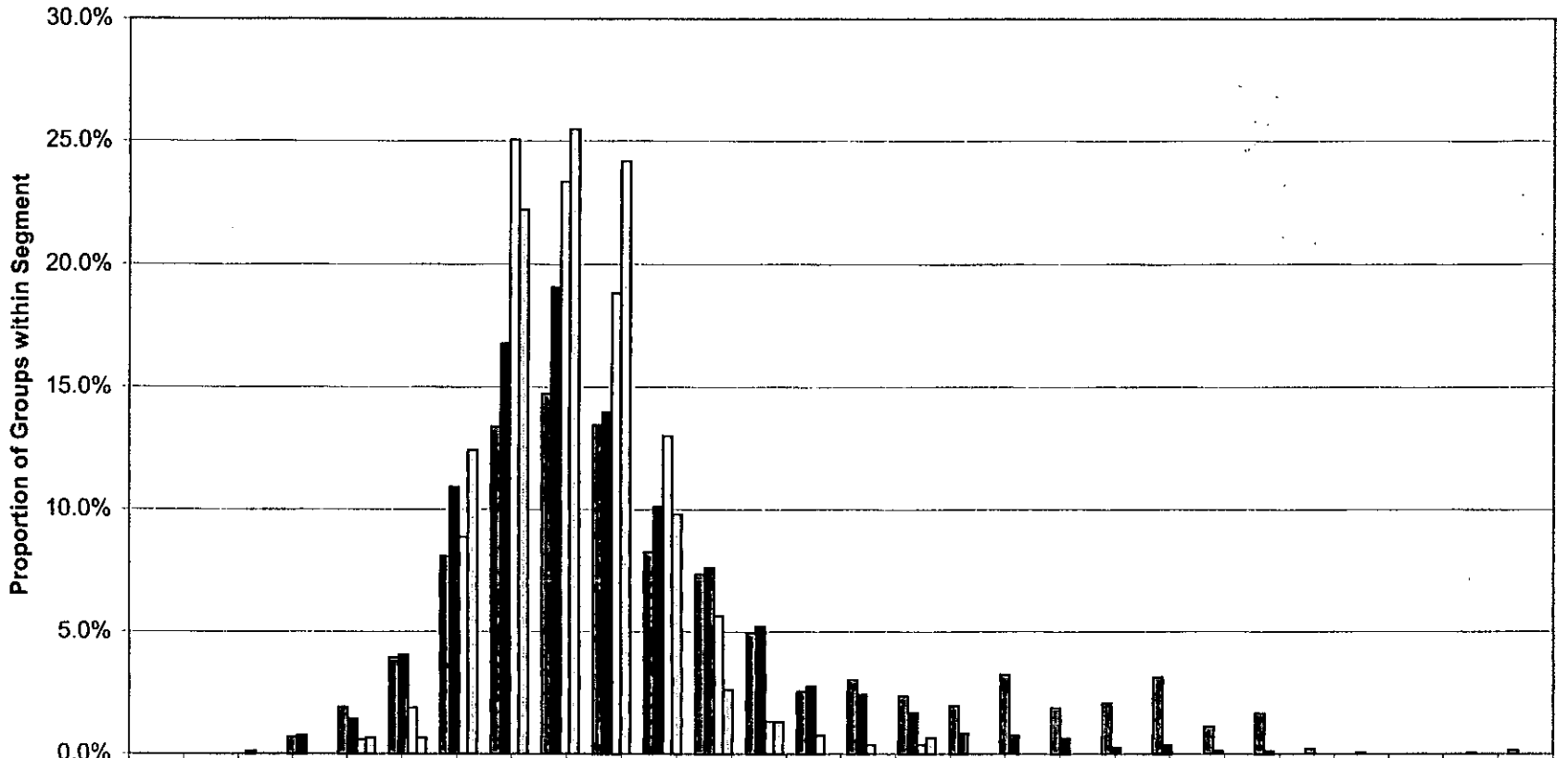
	-30% +	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70% +
25-49	0.0%	0.0%	0.1%	0.4%	1.0%	1.0%	0.6%	0.0%	0.0%	0.0%	0.0%
10-24	0.0%	0.0%	0.3%	1.3%	2.9%	2.9%	1.5%	0.9%	0.3%	0.2%	0.2%
2-9	0.6%	0.9%	2.0%	5.0%	8.2%	9.2%	6.6%	4.9%	3.0%	1.8%	3.5%
1	0.3%	0.6%	0.9%	5.2%	8.8%	7.2%	4.4%	5.0%	2.2%	1.6%	4.5%

Rate Change
min -90%, max 650%

NH Insurance Department
July 2004
Source: Special Data Request to Carriers

Initial Distribution: SB110 Oversight Committee

2003 PMPM Relative to Median (265) - 1st Quarter Renewals



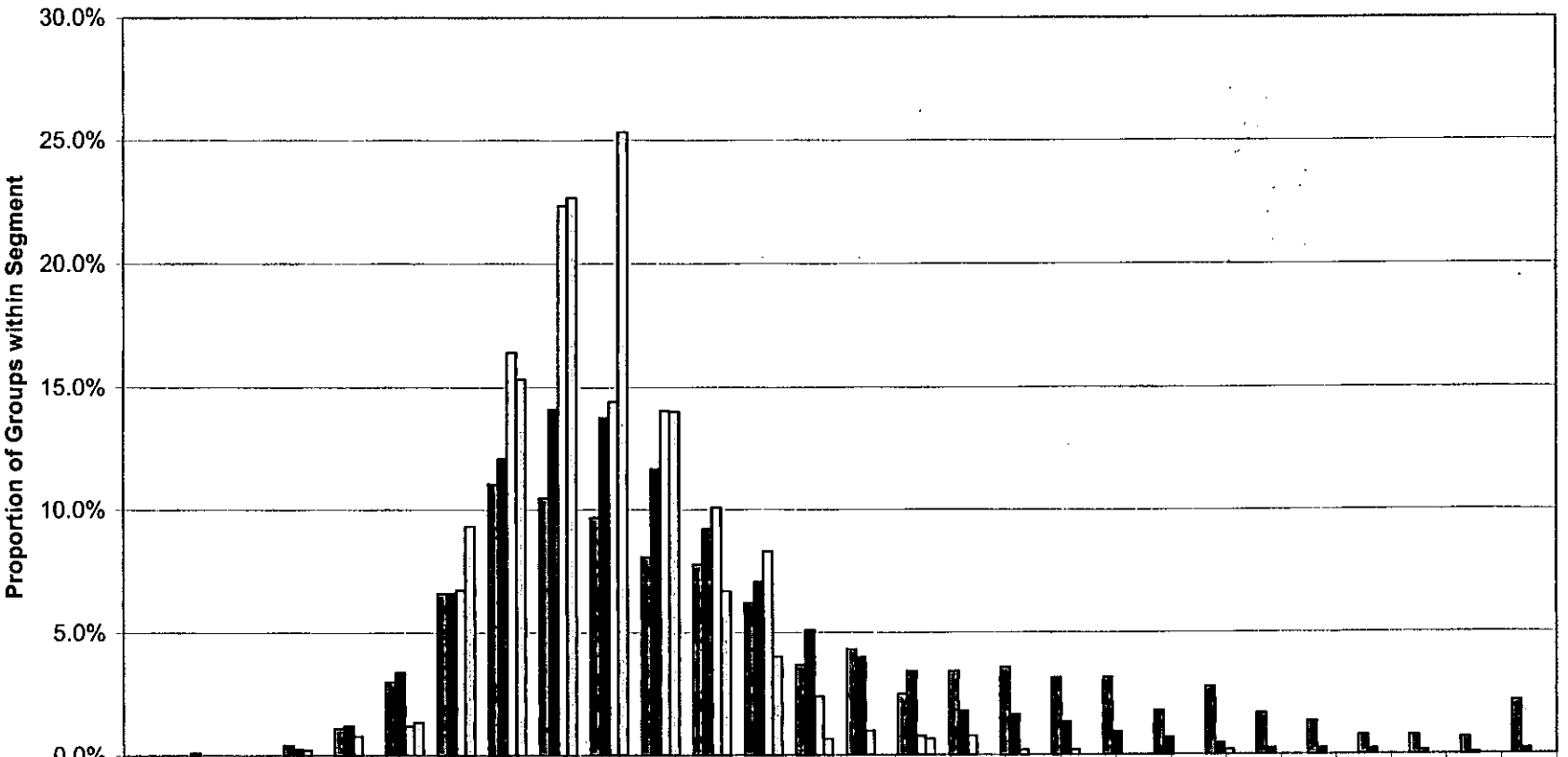
	25	55	85	115	145	175	205	265	295	325	355	385	415	445	475	505	535	565	595	625	685	715	745	775	805	835
1	0.0%	0.0%	0.0%	0.7%	1.9%	3.9%	8.1%	14.7%	13.4%	8.2%	7.3%	4.9%	2.5%	3.0%	2.3%	2.0%	3.2%	1.9%	2.1%	3.1%	1.6%	0.2%	0.1%	0.0%	0.0%	0.2%
2-9	0.0%	0.0%	0.1%	0.8%	1.4%	4.0%	10.9%	19.0%	14.0%	10.1%	7.6%	5.2%	2.8%	2.4%	1.7%	0.8%	0.8%	0.6%	0.3%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
10-24	0.0%	0.0%	0.0%	0.0%	0.6%	1.9%	8.9%	23.4%	18.8%	13.0%	5.6%	1.3%	0.8%	0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.0%	0.0%	0.7%	0.7%	12.4%	25.5%	24.2%	9.8%	2.6%	1.3%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PMPM

NH Insurance Department
July 2004
Source: Special Data Request to Carriers

Initial Distribution: SB110 Oversight Committee

2004 PMPM Relative to Median (295) - 1st Quarter Renewals



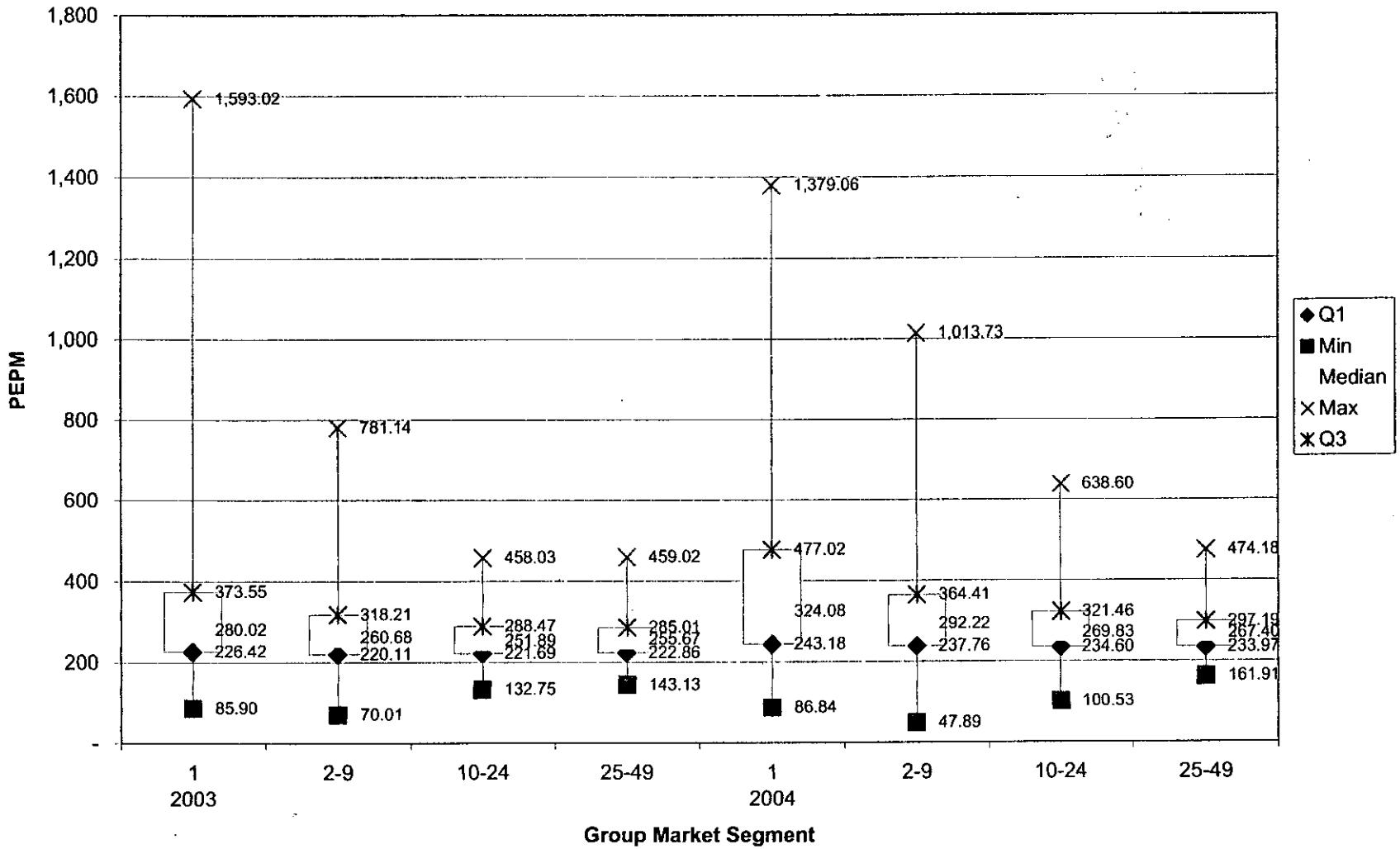
	25	55	85	115	145	175	205	265	295	325	355	385	415	445	475	505	535	565	595	625	685	715	745	775	805	835
1	0.0%	0.0%	0.0%	0.4%	1.1%	3.0%	6.6%	10.5%	9.7%	8.1%	7.8%	6.2%	3.7%	4.3%	2.5%	3.4%	3.6%	3.1%	3.1%	1.8%	1.7%	1.4%	0.8%	0.8%	0.7%	2.1%
2-9	0.0%	0.1%	0.0%	0.3%	1.2%	3.4%	6.6%	14.1%	13.8%	11.7%	9.2%	7.1%	5.1%	4.0%	3.4%	1.8%	1.6%	1.3%	1.0%	0.7%	0.3%	0.3%	0.2%	0.2%	0.0%	0.2%
10-24	0.0%	0.0%	0.0%	0.2%	0.8%	1.2%	6.7%	22.3%	14.4%	14.0%	10.1%	8.3%	2.4%	1.0%	0.8%	0.8%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	9.3%	22.7%	25.3%	14.0%	6.7%	4.0%	0.7%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PMPM

NH Insurance Department
July 2004
Source: Special Data Request to Carriers

Initial Distribution: SB110 Oversight Committee

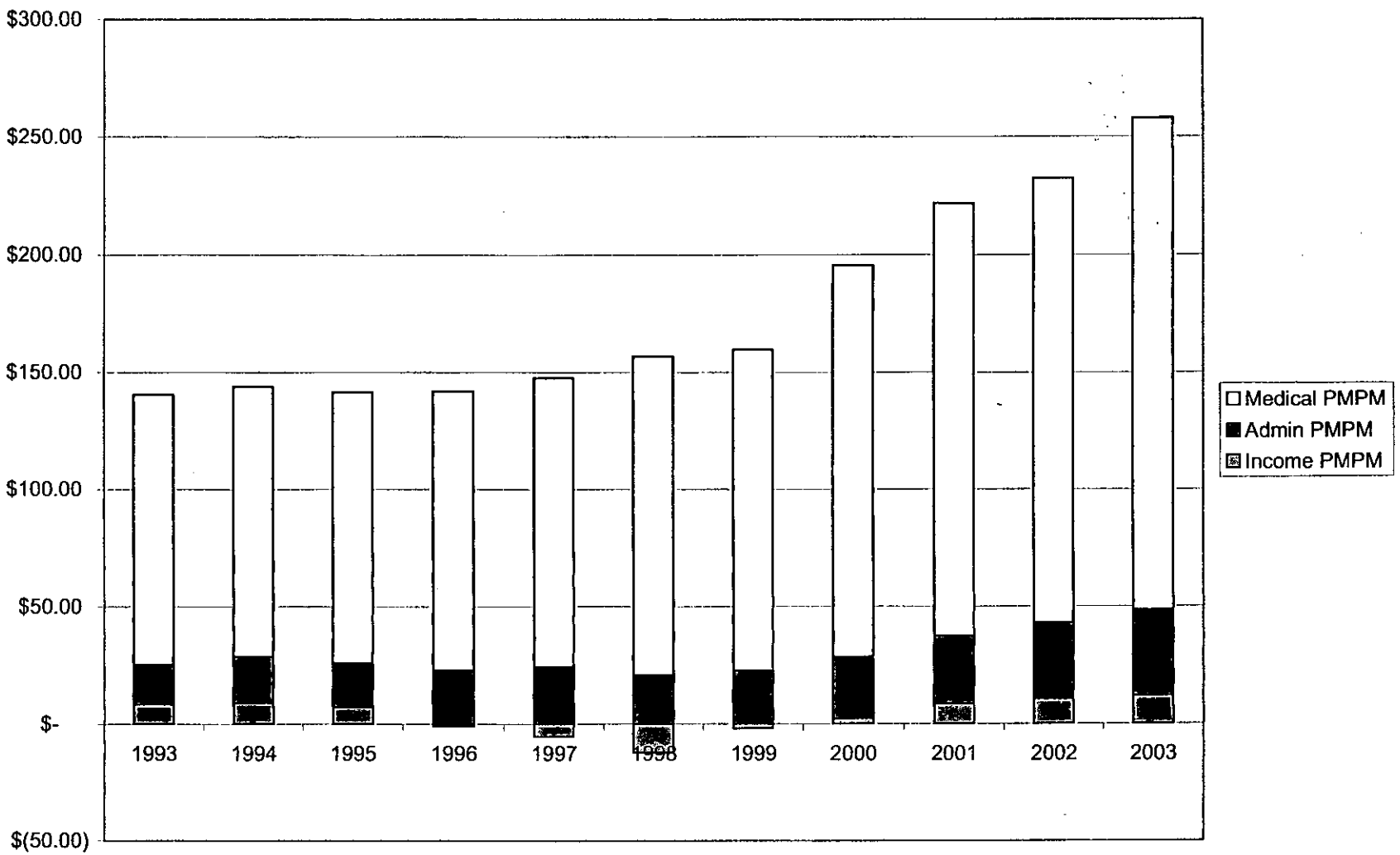
PMPM Box Plot - 1st Quarter Renewals



NH Insurance Department
July 2004
Source: Special Data Request to Carriers

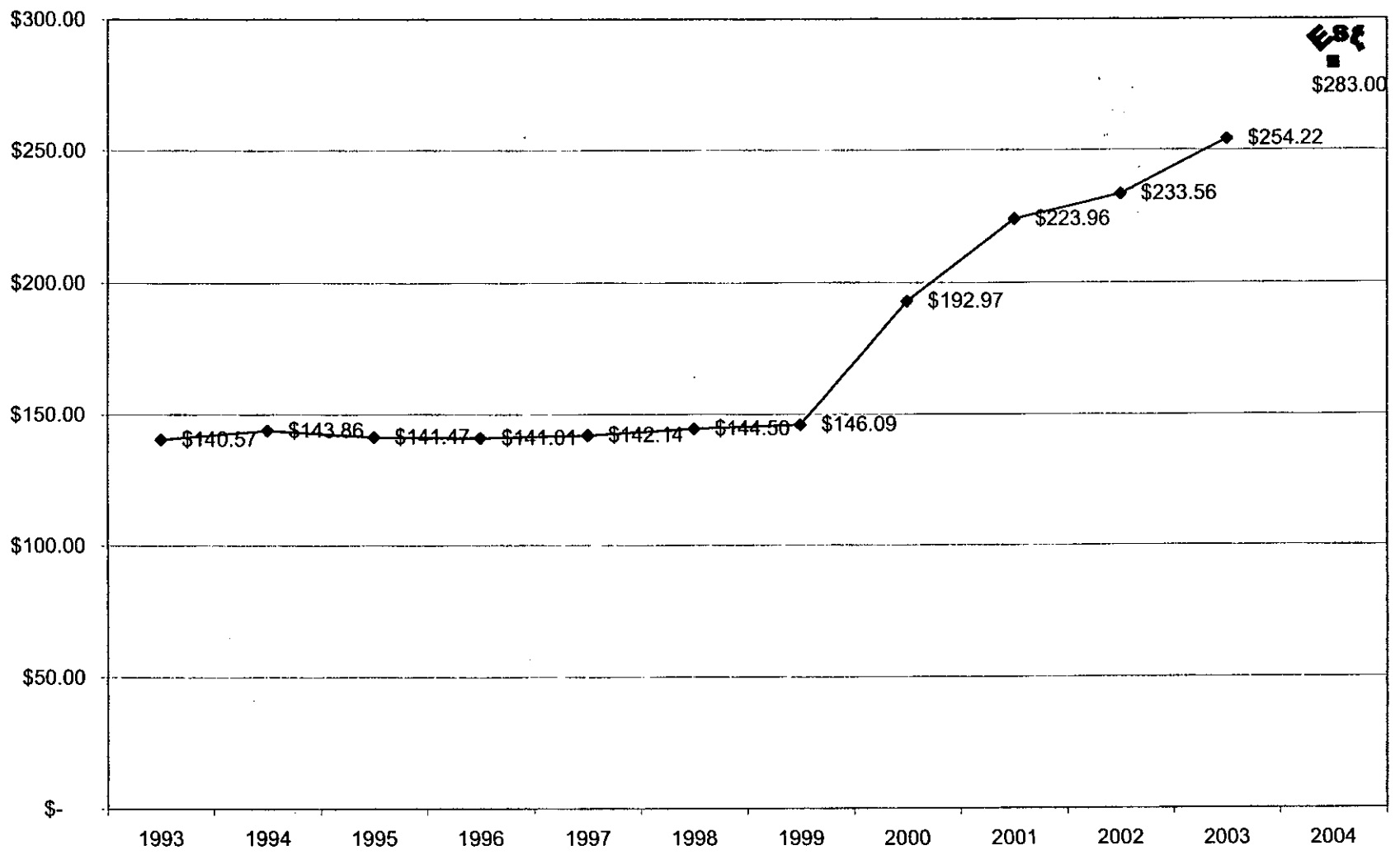
Initial Distribution: SB110 Oversight Committee

PMPM Components



NH Insurance Department
July 2004
Source: HMO Statutory Financial Statements

Per Member Per Month Premium



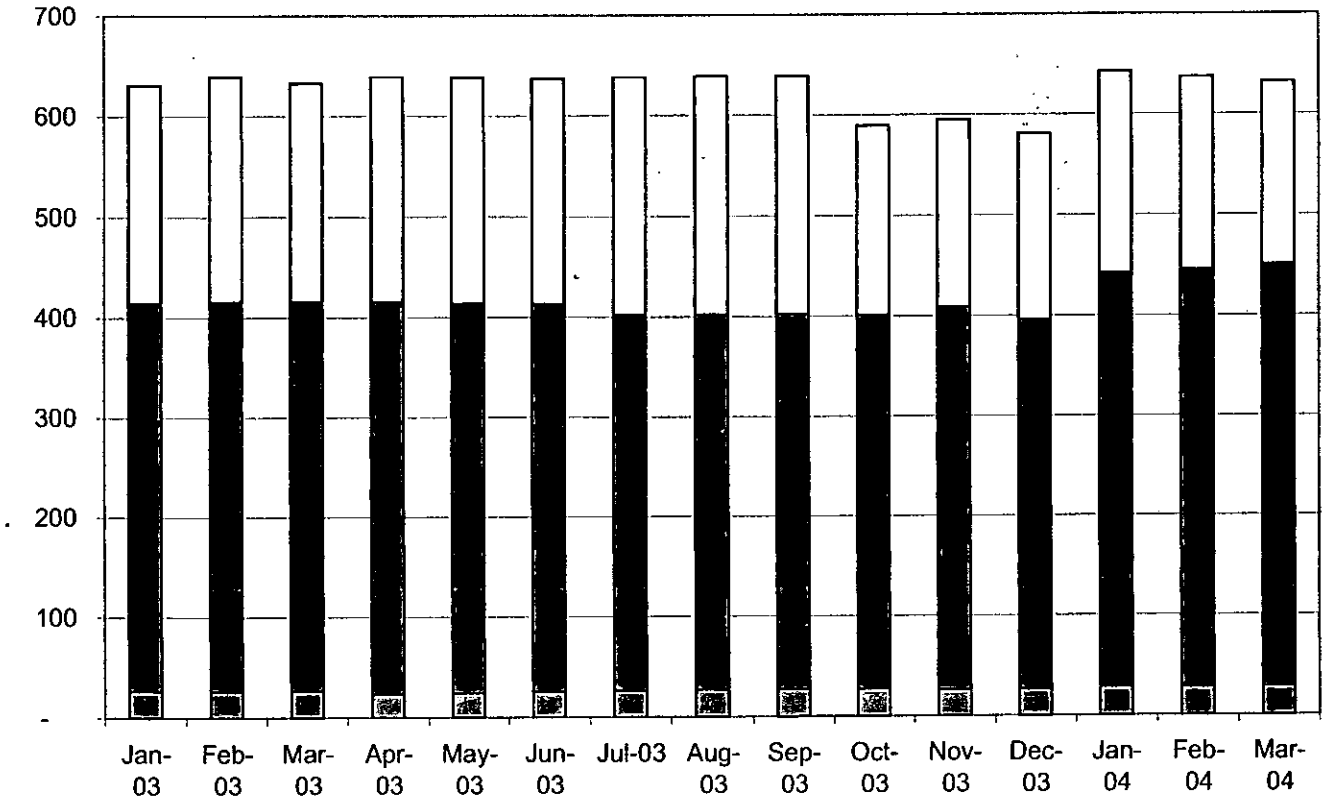
NH Insurance Department
July 2004
Source: HMO Statutory Financial Statements

Components of Premium

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Income PMPM	$ 8.36	$ 9.12	$ 7.25	$ (0.92)	$ (5.44)	$ (12.24)	$ (1.78)	$ 2.26	$ 8.61	$ 10.49	$ 12.06
Admin PMPM	$ 16.95	$ 19.56	$ 18.64	$ 22.78	$ 24.09	$ 20.51	$ 22.68	$ 26.23	$ 28.50	$ 32.36	$ 36.22
Medical PMPM	$ 115.26	$ 115.18	$ 115.58	$ 119.15	$ 123.49	$ 136.23	$ 137.09	$ 167.03	$ 184.73	$ 189.63	$ 209.69
PMPM	$ 140.57	$ 143.86	$ 141.47	$ 141.01	$ 142.14	$ 144.50	$ 146.09	$ 192.97	$ 223.96	$ 233.56	$ 254.22

NH Insurance Department
July 2004
Source: HMO Statutory Financial Statements

Reported Covered Lives for Assessment (000)



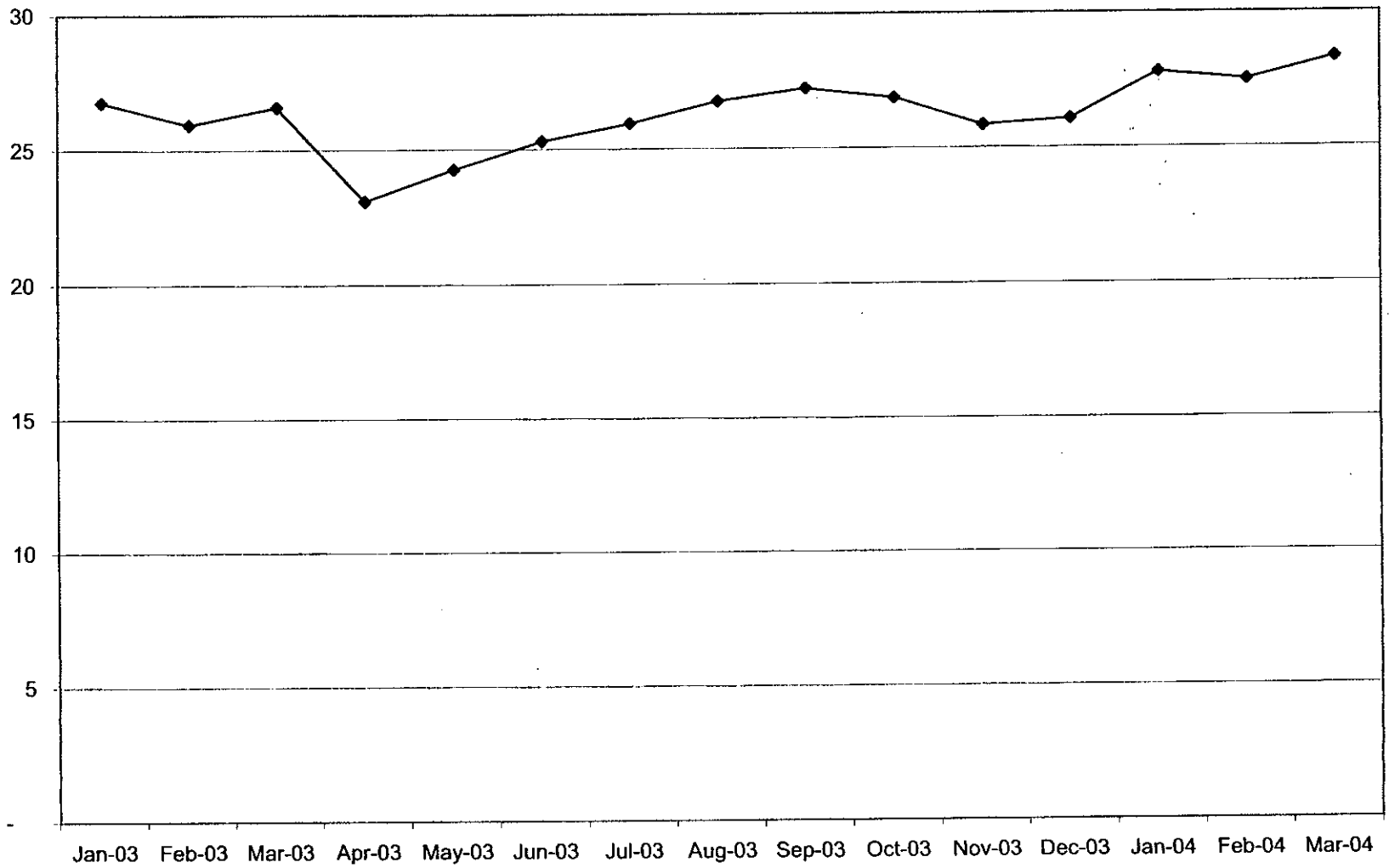
	01/03	02/03	03/03	04/03	05/03	06/03	07/03	08/03	09/03	10/03	11/03	12/03	01/04	02/04	03/04
☐ Group - Self Funded w/ Stop Loss	217	225	218	224	225	224	236	237	237	189	187	185	201	192	182
■ Group - Fully Insured	387	389	389	392	389	388	376	375	375	374	382	370	414	418	422
▨ Individual	27	26	27	23	24	25	26	27	27	27	26	26	28	27	28

NH Insurance Department
August 2004

Initial Distribution: SB110 Oversight Committee

Source: NH Individual Health Plan Benefit Association

Individual (000)

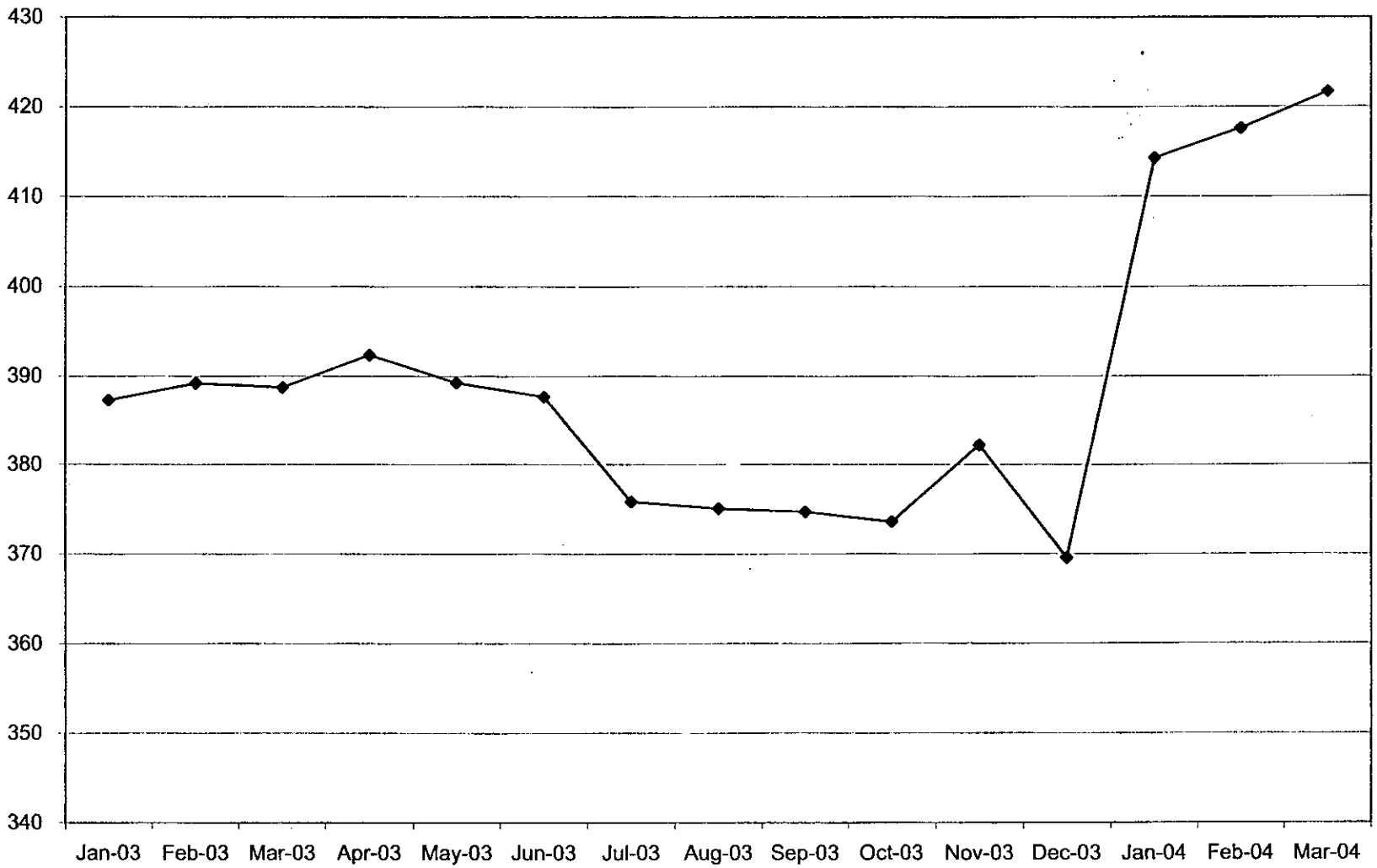


NH Insurance Department
August 2004

Initial Distribution: SB110 Oversight Committee

Source: NH Individual Health Plan Benefit Association

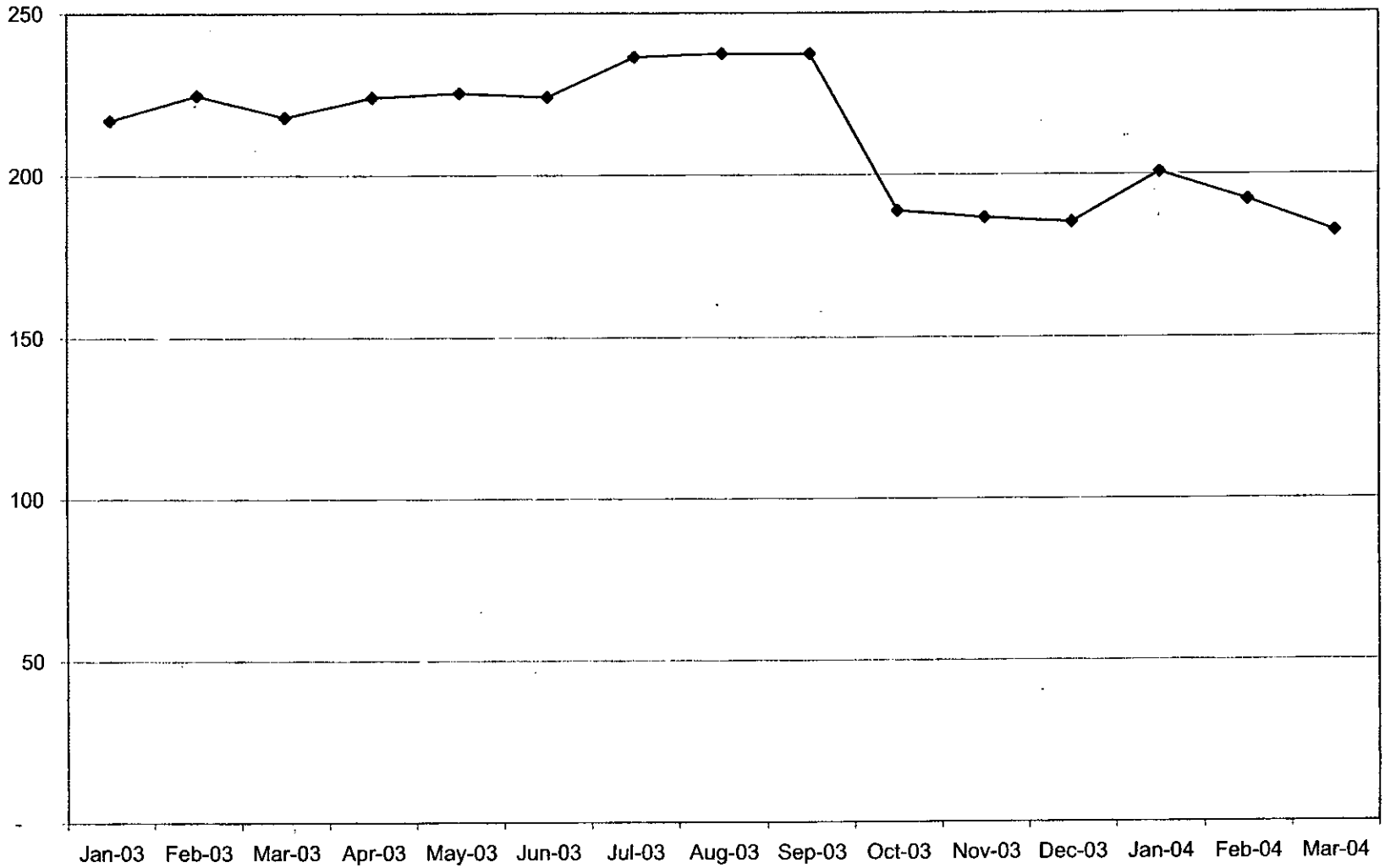
Group - Fully Insured (000)



NH Insurance Department
August 2004
Source: NH Individual Health Plan Benefit Association

Initial Distribution: SB110 Oversight Committee

Group - Self Funded w/ Stop Loss (000)



NH Insurance Department
August 2004

Initial Distribution: SB110 Oversight Committee

Source: NH Individual Health Plan Benefit Association

Small Group Renewal Activity
August 2004

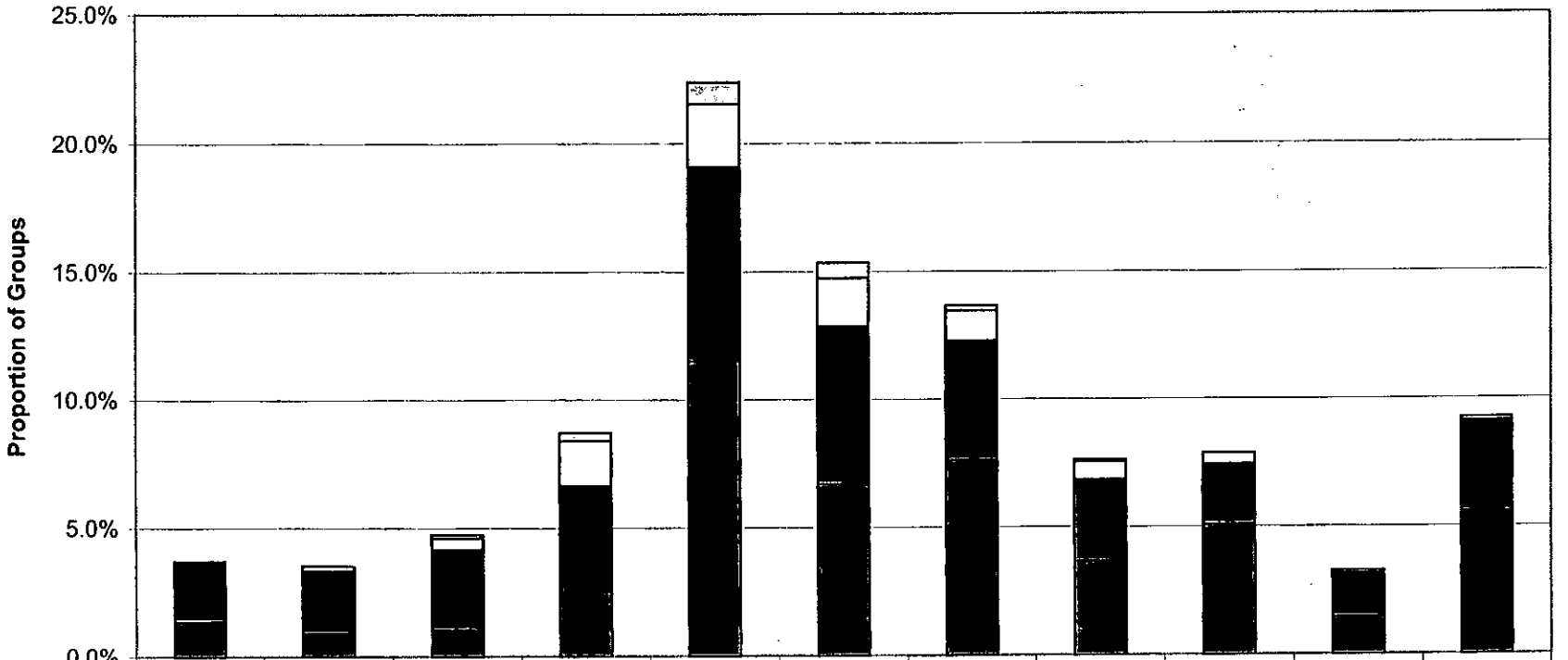
This is an update of information previously published by the Department. These charts have been developed to assist policy makers in their work and to provide a better understanding of New Hampshire's health insurance markets. The Department cautions that this data is incomplete and more data is required before the full impact of SB 110 on the small group market can be assessed. The initial data does support some preliminary conclusions about SB 110, including the pattern of variation of rates among the different market segments.

The Department was not able to collect information from every carrier. These charts are based on information provided by the HMO's and reflect only that market segment. This represents over 90% of the small group market.

The Department previously modeled the expected variation in premium rates upon the implementation of SB 110. The actual variation in second quarter renewals and for the first half of 2004 is presented on a PEPM basis, Per Employee Per Month, and on a PMPM basis, Per Member Per Month. The first and second quarter renewal data shows slightly more variation in rates than what was predicted by the Department's model.

The first quarter activity includes information on rates for approximately 5100 employers. The second quarter activity includes information on rates for approximately 3800 employers.

PEPM Analysis
2nd Quarter Renewals

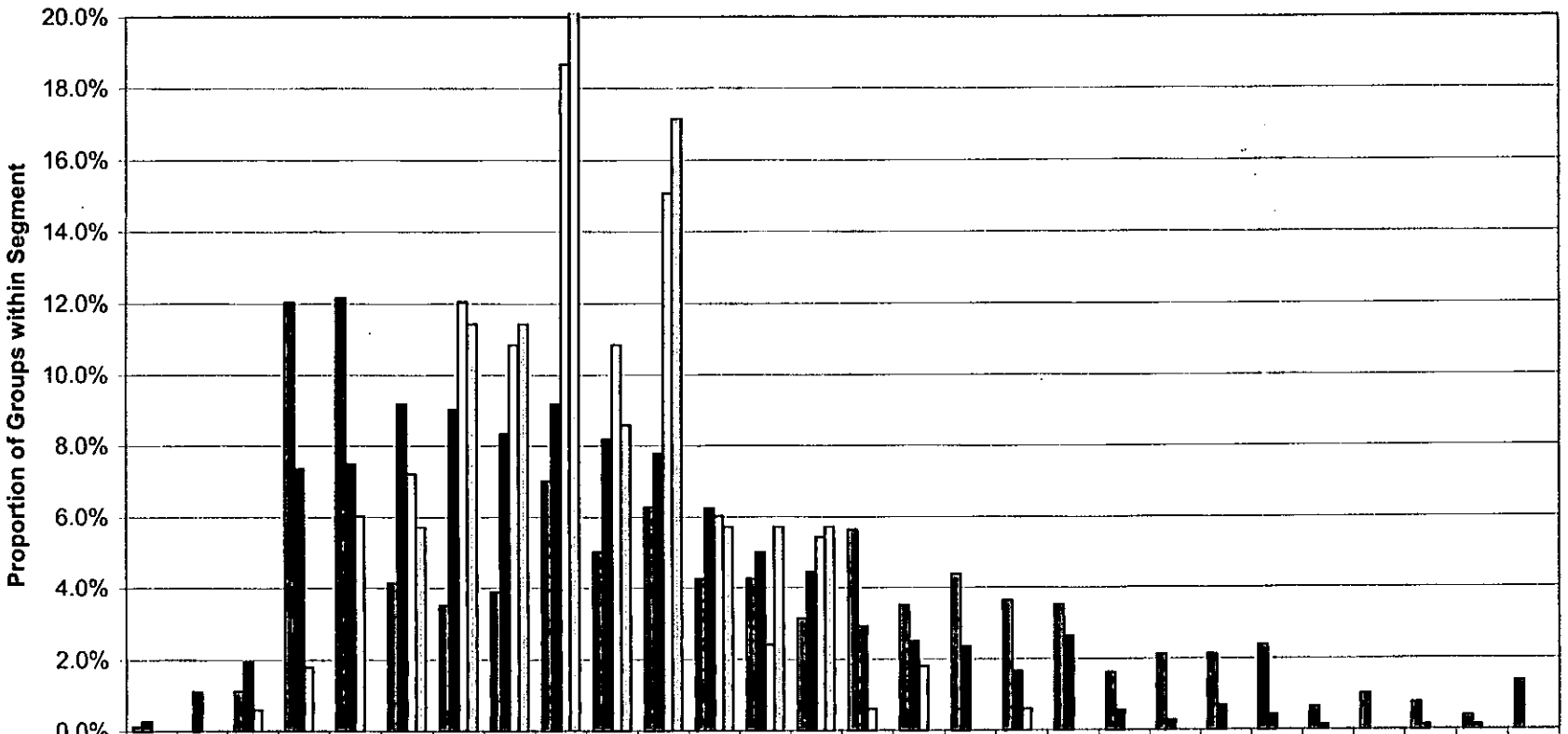


	-30% +	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70% +
25-49	0.1%	0.0%	0.1%	0.3%	0.8%	0.6%	0.2%	0.1%	0.0%	0.0%	0.0%
10-24	0.0%	0.2%	0.5%	1.8%	2.5%	1.9%	1.2%	0.7%	0.5%	0.1%	0.1%
2-9	2.3%	2.4%	3.1%	4.1%	7.5%	6.2%	4.7%	3.2%	2.3%	1.7%	3.6%
1	1.4%	0.9%	1.0%	2.5%	11.5%	6.7%	7.6%	3.6%	5.1%	1.4%	5.5%

Rate Change
min -70%, max 240%

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

2003 PEPM Relative to Median (500) - 2nd Quarter Renewals

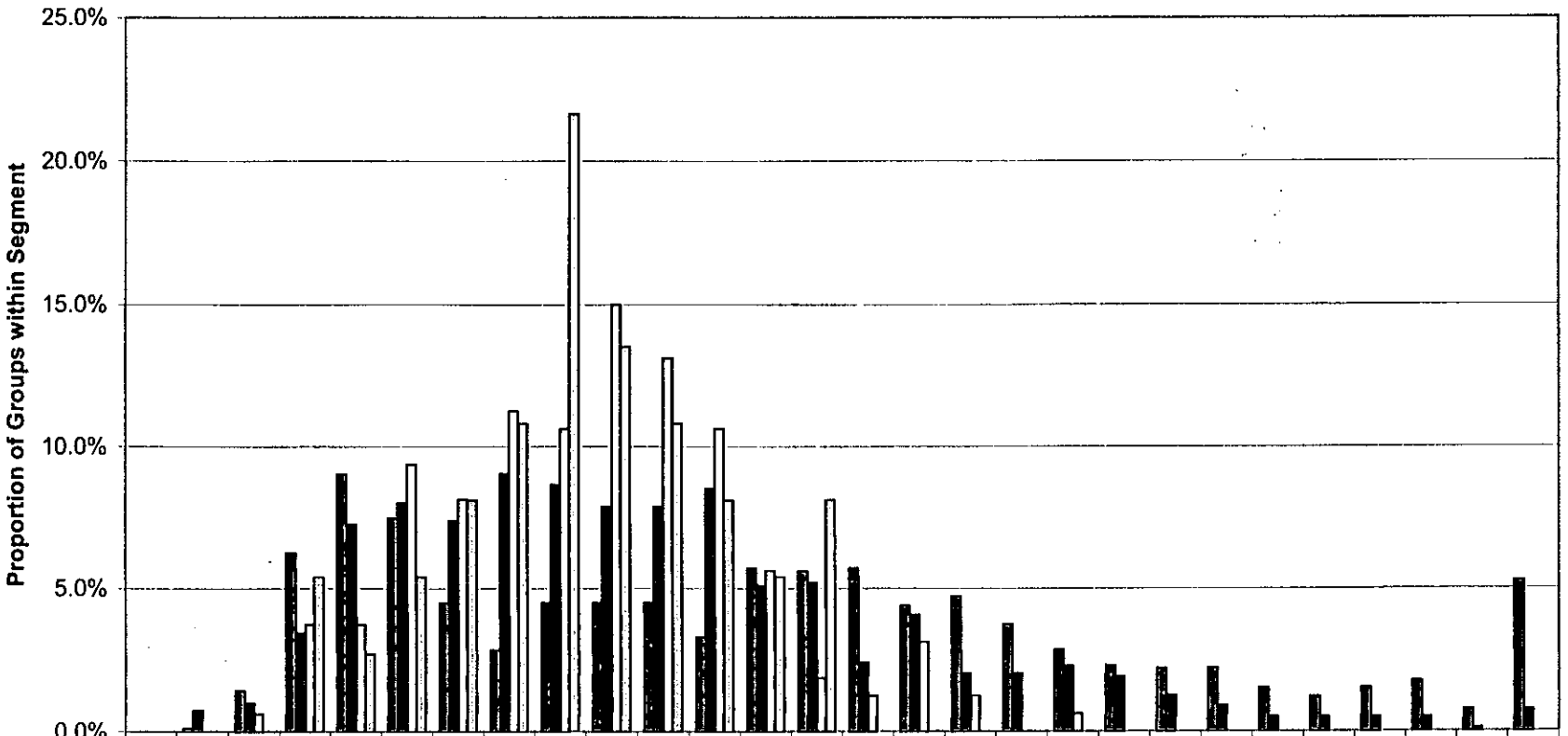


	100	150	200	250	300	350	400	450	500	550	600	650	700	750	800	850	900	950	1000	1050	1100	1150	1200	1250	1300	1350	1400	1450 +
1	0.1%	0.0%	1.1%	12.0	12.2	4.1%	3.5%	3.9%	7.0%	5.0%	6.3%	4.3%	4.3%	3.1%	5.6%	3.5%	4.4%	3.6%	3.5%	1.6%	2.1%	2.1%	2.4%	0.6%	1.0%	0.8%	0.4%	1.4%
2-9	0.3%	1.1%	1.9%	7.4%	7.5%	9.2%	9.0%	8.3%	9.2%	8.2%	7.8%	6.3%	5.0%	4.4%	2.9%	2.5%	2.4%	1.7%	2.6%	0.6%	0.3%	0.7%	0.4%	0.1%	0.0%	0.1%	0.1%	0.0%
10-24	0.0%	0.0%	0.6%	1.8%	6.0%	7.2%	12.0	10.8	18.7	10.8	15.1	6.0%	2.4%	5.4%	0.6%	1.8%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.0%	0.0%	0.0%	5.7%	11.4	11.4	28.6	8.6%	17.1	5.7%	5.7%	5.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PEPM

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

2004 PEPM Relative to Median (550) - 2nd Quarter Renewals

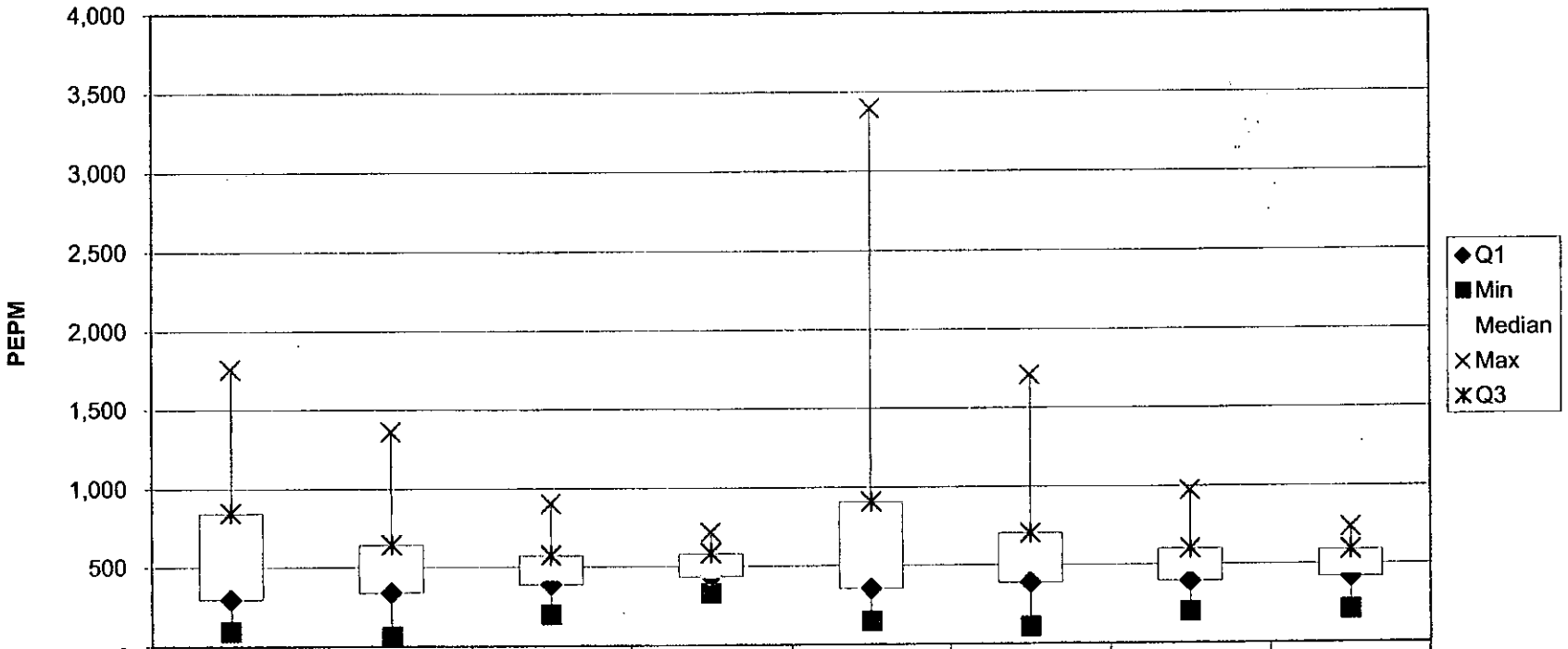


	100	150	200	250	300	350	400	450	500	550	600	650	700	750	800	850	900	950	1000	1050	1100	1150	1200	1250	1300	1350	1400	1450 +
1	0.0%	0.1%	1.4%	6.3%	9.0%	7.5%	4.5%	2.9%	4.5%	4.5%	4.5%	3.3%	5.7%	5.6%	5.7%	4.4%	4.7%	3.7%	2.9%	2.3%	2.2%	2.2%	1.5%	1.2%	1.5%	1.8%	0.8%	5.3%
2-9	0.0%	0.8%	1.0%	3.4%	7.3%	8.0%	7.4%	9.0%	8.7%	7.9%	7.9%	8.5%	5.1%	5.2%	2.4%	4.1%	2.0%	2.0%	2.3%	1.9%	1.3%	0.9%	0.5%	0.5%	0.5%	0.5%	0.1%	0.8%
10-24	0.0%	0.0%	0.6%	3.8%	3.8%	9.4%	8.1%	11.3	10.6	15.0	13.1	10.6	5.6%	1.9%	1.3%	3.1%	1.3%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.0%	5.4%	2.7%	5.4%	8.1%	10.8	21.6	13.5	10.8	8.1%	5.4%	8.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PEPM

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

PEPM Box Plot - 2nd Quarter Renewals

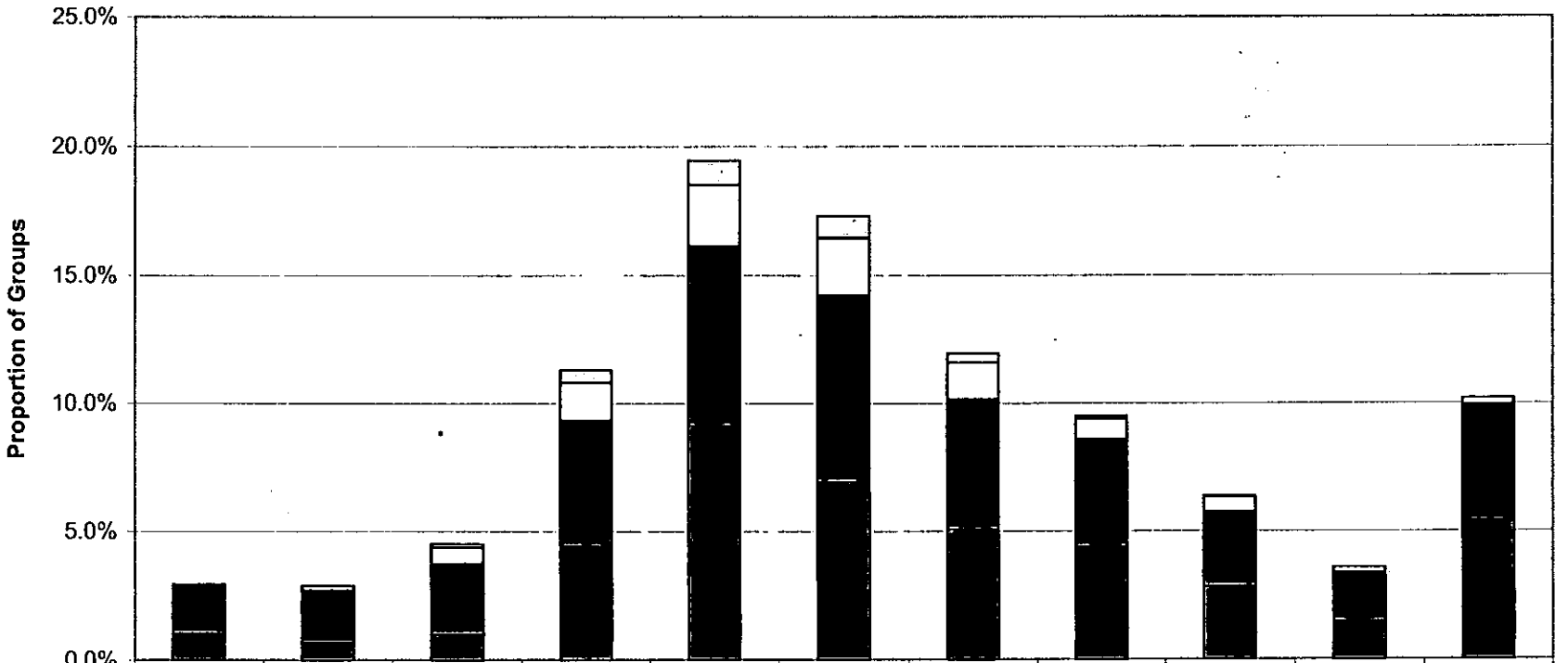


	2003				2004			
	1	2-9	10-24	25-49	1	2-9	10-24	25-49
◆ Q1	295.62	338.42	388.01	433.26	354.37	385.42	391.05	414.22
■ Min	91.59	59.17	194.05	324.83	144.92	103.96	195.56	205.78
Median	554.55	476.87	478.38	488.03	664.19	523.33	510.43	496.43
× Max	1,756.17	1,359.87	902.23	713.78	3,395.14	1,706.98	970.40	733.08
✱ Q3	843.99	639.46	572.18	580.12	905.90	699.84	596.40	588.42

Group Market Segment

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

PEPM Analysis
2nd Qtr YTD Renewals

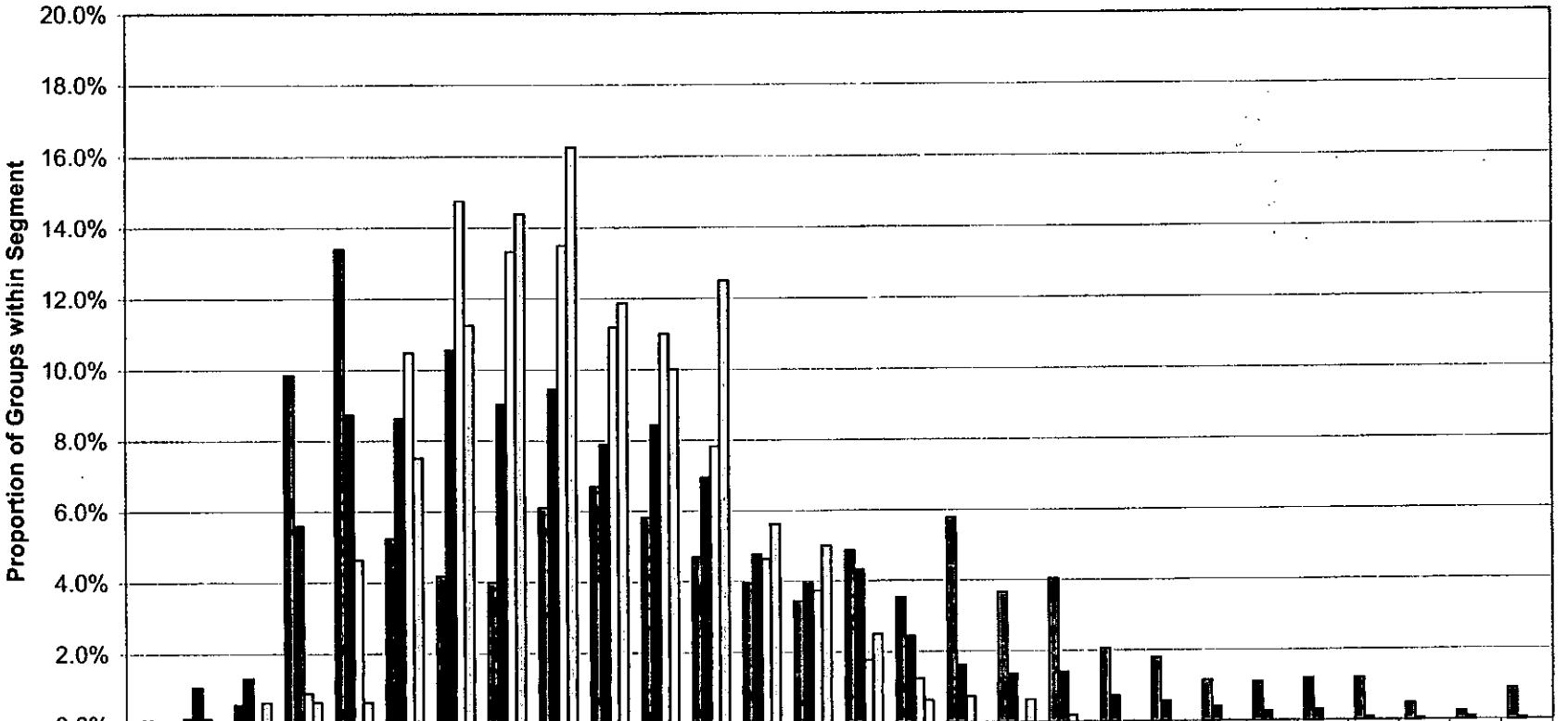


	-30% +	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70% +
□25-49	0.0%	0.0%	0.1%	0.5%	1.0%	0.8%	0.3%	0.1%	0.0%	0.0%	0.0%
□10-24	0.0%	0.2%	0.6%	1.5%	2.4%	2.2%	1.4%	0.8%	0.6%	0.2%	0.3%
■2-9	1.8%	2.0%	2.7%	4.9%	7.0%	7.3%	5.1%	4.2%	2.9%	1.9%	4.5%
■1	1.0%	0.7%	1.0%	4.4%	9.1%	6.9%	5.1%	4.4%	2.8%	1.5%	5.4%

Rate Change
min -90%, max 240%

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

2003 PEPM Relative to Median (490) - 2nd Qtr YTD Renewals

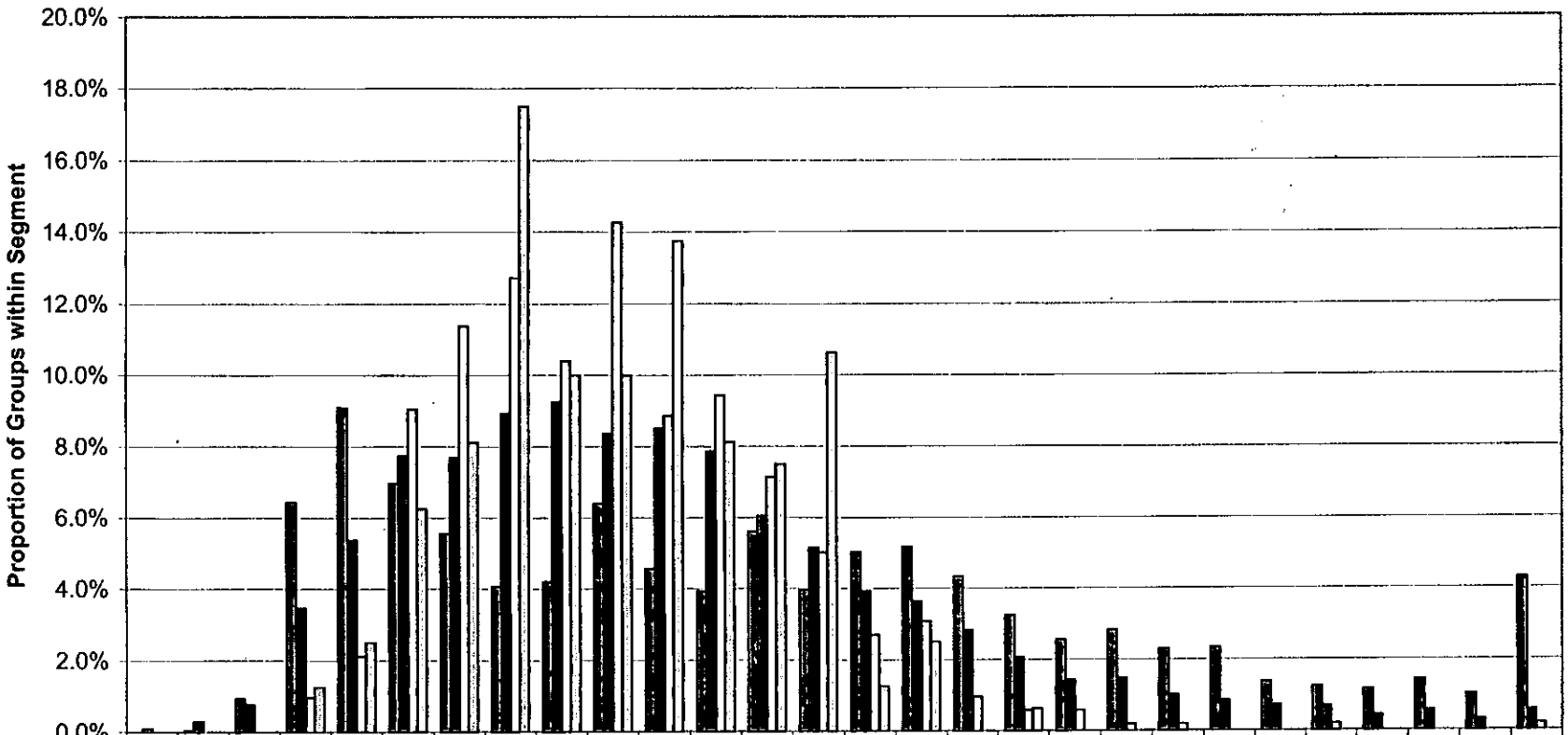


	90	140	190	240	290	340	390	440	490	540	590	640	690	740	790	840	890	940	990	1040	1090	1140	1190	1240	1290	1340	1390	1440 +
1	0.0%	0.2%	0.6%	9.9%	13.4	5.2%	4.2%	4.0%	6.1%	6.7%	5.8%	4.7%	3.9%	3.4%	4.9%	3.5%	5.8%	3.7%	4.0%	2.1%	1.8%	1.1%	1.1%	1.2%	1.2%	0.5%	0.2%	0.9%
2-9	0.1%	1.1%	1.3%	5.6%	8.7%	8.6%	10.5	9.0%	9.4%	7.9%	8.4%	6.9%	4.7%	3.9%	4.3%	2.5%	1.6%	1.4%	1.4%	0.7%	0.6%	0.4%	0.3%	0.3%	0.1%	0.0%	0.1%	0.0%
10-24	0.0%	0.2%	0.0%	0.9%	4.6%	10.5	14.7	13.3	13.5	11.2	11.0	7.8%	4.6%	3.7%	1.8%	1.2%	0.7%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.6%	0.6%	0.6%	7.5%	11.3	14.4	16.3	11.9	10.0	12.5	5.6%	5.0%	2.5%	0.6%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PEPM

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

2004 PEPM Relative to Median (540) - 2nd Qtr YTD Renewals

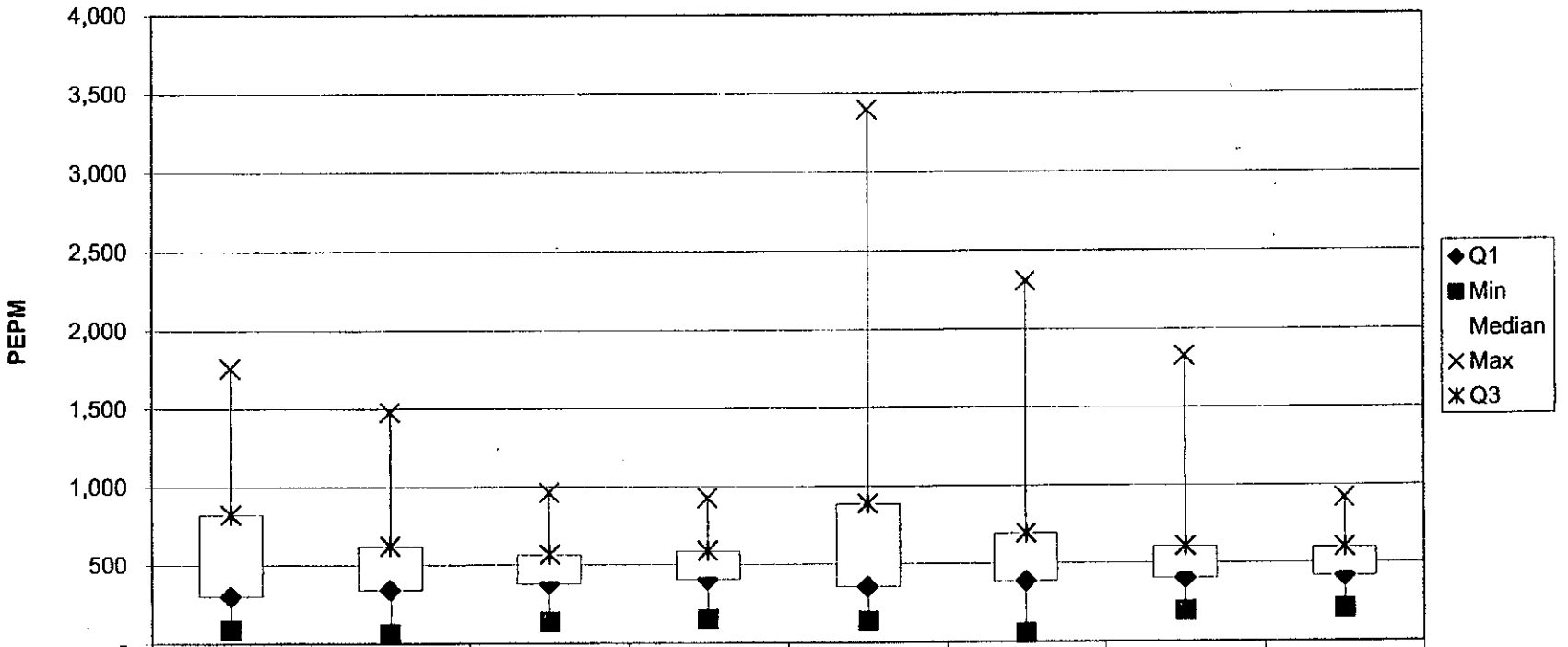


	90	140	190	240	290	340	390	440	490	540	590	640	690	740	790	840	890	940	990	1040	1090	1140	1190	1240	1290	1340	1390	1440 +
1	0.0%	0.0%	0.9%	6.4%	9.1%	7.0%	5.6%	4.1%	4.2%	6.4%	4.5%	3.9%	5.6%	4.0%	5.0%	5.2%	4.3%	3.3%	2.6%	2.8%	2.3%	2.3%	1.4%	1.2%	1.1%	1.4%	1.0%	4.3%
2-9	0.1%	0.3%	0.8%	3.5%	5.4%	7.7%	7.7%	8.9%	9.3%	8.4%	8.5%	7.9%	6.0%	5.2%	3.9%	3.6%	2.8%	2.1%	1.4%	1.5%	1.0%	0.8%	0.7%	0.7%	0.4%	0.5%	0.3%	0.5%
10-24	0.0%	0.0%	0.0%	1.0%	2.1%	9.1%	11.4	12.7	10.4	14.3	8.9%	9.4%	7.1%	5.0%	2.7%	3.1%	1.0%	0.6%	0.6%	0.2%	0.2%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.2%
25-49	0.0%	0.0%	0.0%	1.3%	2.5%	6.3%	8.1%	17.5	10.0	10.0	13.8	8.1%	7.5%	10.6	1.3%	2.5%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PEPM

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

PEPM Box Plot - 2nd Qtr YTD Renewals

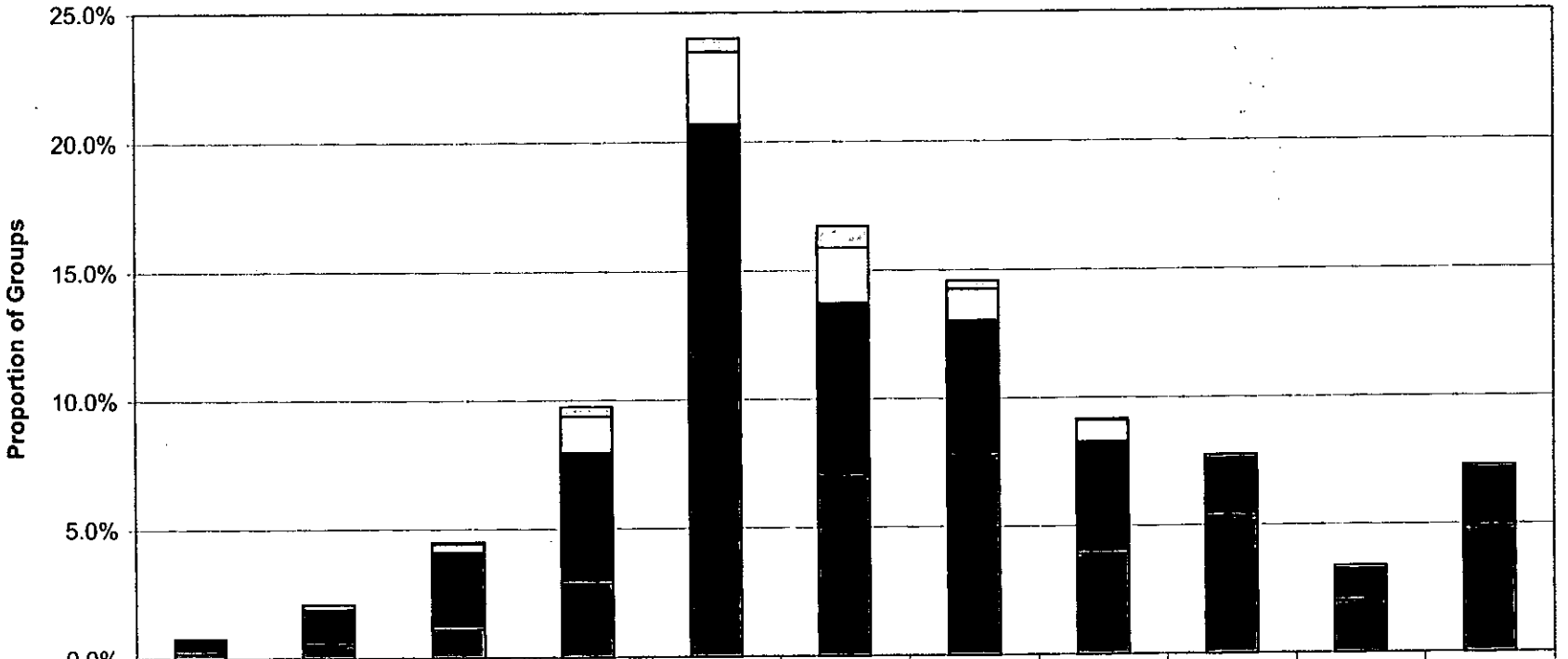


	2003				2004			
	1	2-9	10-24	25-49	1	2-9	10-24	25-49
◆Q1	300.50	340.29	377.86	403.11	355.87	386.06	402.83	413.06
■Min	85.90	59.17	134.76	147.90	133.22	51.48	192.87	205.78
Median	537.60	469.88	462.46	487.77	611.50	525.28	501.48	504.85
×Max	1,756.17	1,475.48	961.36	925.89	3,395.14	2,304.96	1,824.58	916.21
✳Q3	820.28	617.95	564.95	585.76	884.92	692.96	605.24	598.50

Group Market Segment

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

PMPM Analysis
2nd Qtr Renewals

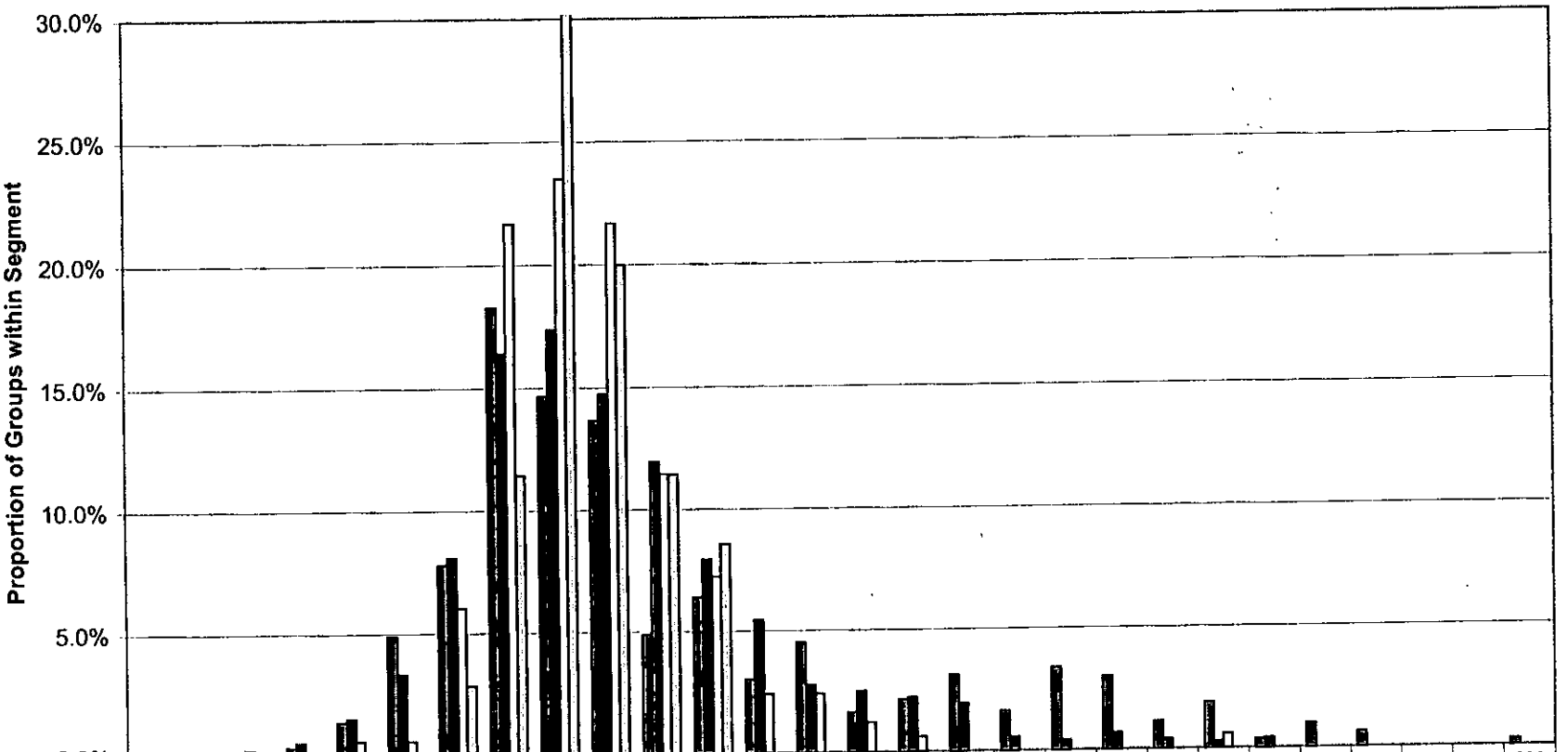


	-30% +	-20%	-10%	0%	10%	20%	30%	40%	50%	60%	70% +
□25-49	0.0%	0.0%	0.1%	0.4%	0.5%	0.8%	0.3%	0.1%	0.0%	0.0%	0.0%
□10-24	0.0%	0.2%	0.3%	1.4%	2.8%	2.1%	1.2%	0.8%	0.1%	0.1%	0.1%
■2-9	0.6%	1.4%	3.0%	5.1%	8.9%	6.8%	5.3%	4.4%	2.3%	1.2%	2.3%
■1	0.2%	0.5%	1.1%	2.9%	11.8%	7.0%	7.7%	3.9%	5.3%	2.0%	4.9%

Rate Change
min -90%, max 650%

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

2003 PMPM Relative to Median (230) - 2nd Qtr Renewals

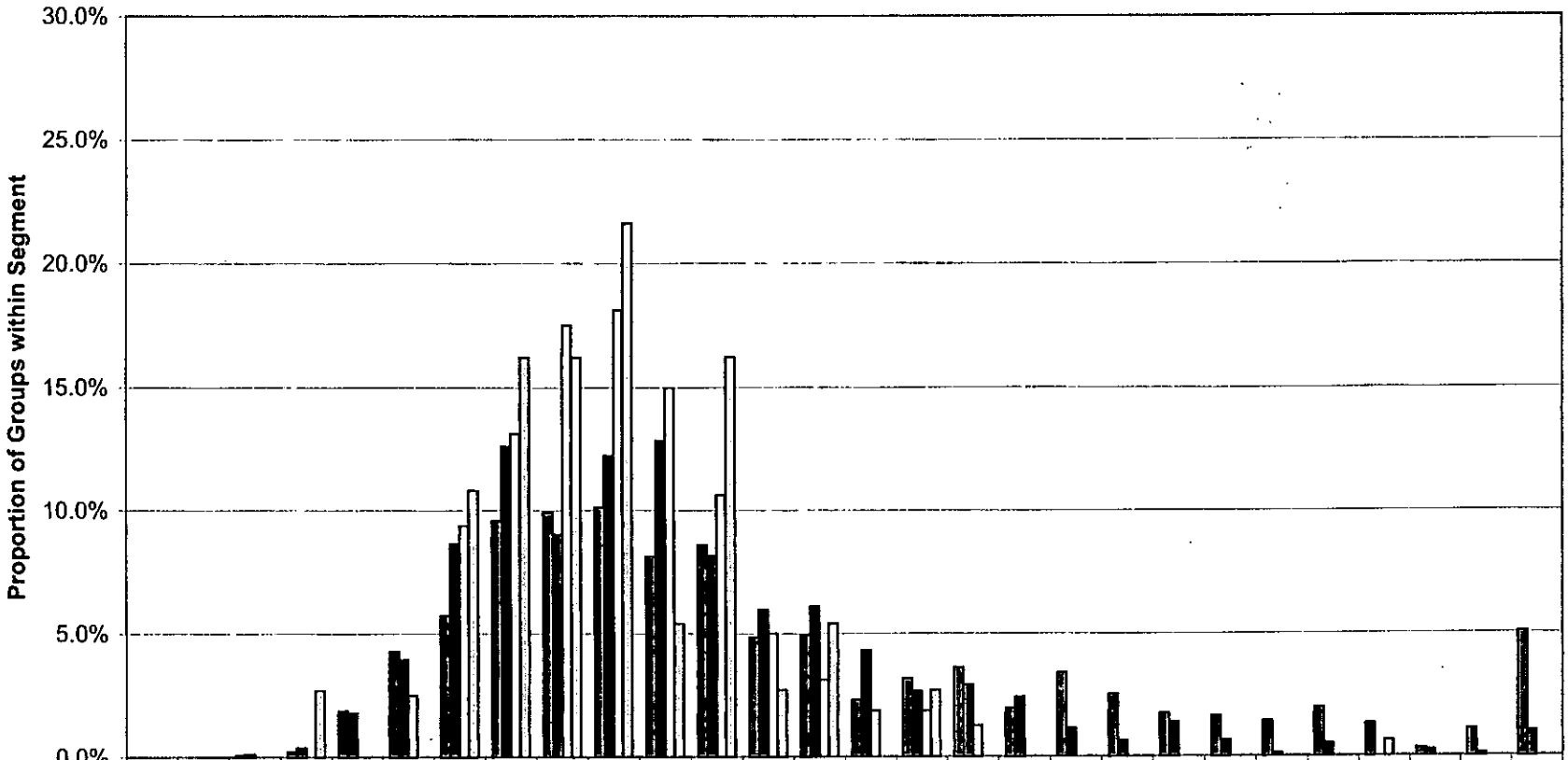


	25	55	85	115	145	175	205	235	265	295	325	355	385	415	445	475	505	535	565	595	625	655	685	715	745	775	805	835
1	0.0%	0.0%	0.0%	0.4%	1.4%	4.9%	7.8%	18.3	14.7	13.7	4.9%	6.4%	3.0%	4.5%	1.6%	2.1%	3.1%	1.6%	3.4%	3.0%	1.1%	1.9%	0.4%	1.0%	0.6%	0.0%	0.0%	0.3%
2-9	0.0%	0.1%	0.3%	0.6%	1.5%	3.3%	8.1%	16.4	17.4	14.7	12.0	7.9%	5.4%	2.8%	2.5%	2.2%	1.9%	0.6%	0.4%	0.7%	0.4%	0.3%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
10-24	0.0%	0.0%	0.0%	0.0%	0.6%	0.6%	6.0%	21.7	23.5	21.7	11.4	7.2%	2.4%	2.4%	1.2%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	11.4	45.7	20.0	11.4	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PMPM

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

2004 PMPM Relative to Median (300) - 2nd Qtr Renewals

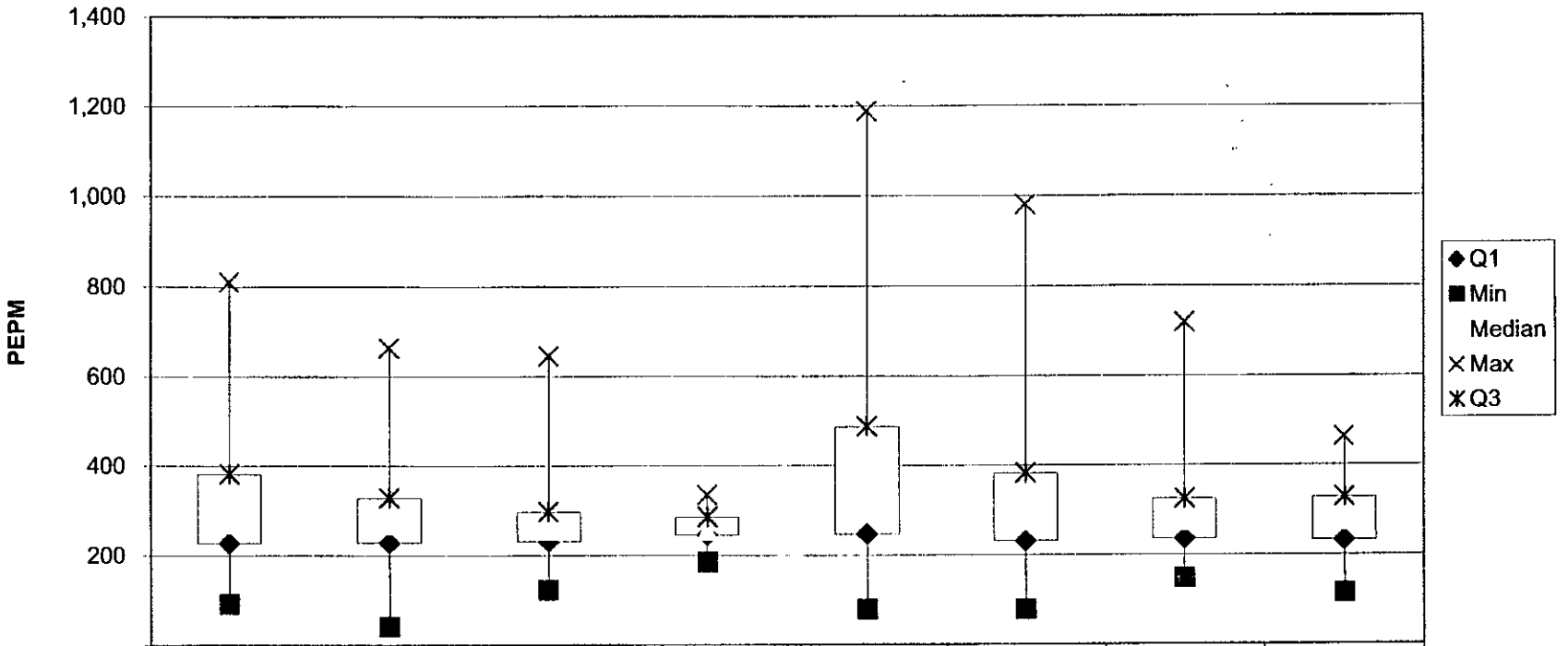


	25	55	85	115	145	175	205	235	265	295	325	355	385	415	445	475	505	535	565	595	625	655	685	715	745	775	805	835
1	0.0%	0.0%	0.1%	0.2%	1.9%	4.3%	5.7%	9.6%	9.9%	10.1	8.1%	8.6%	4.8%	5.0%	2.3%	3.2%	3.6%	2.0%	3.4%	2.5%	1.8%	1.7%	1.4%	2.0%	1.3%	0.3%	1.1%	5.1%
2-9	0.0%	0.0%	0.1%	0.4%	1.8%	3.9%	8.7%	12.6	9.0%	12.2	12.8	8.1%	6.0%	6.1%	4.3%	2.7%	2.9%	2.4%	1.1%	0.6%	1.4%	0.6%	0.1%	0.5%	0.0%	0.3%	0.1%	1.0%
10-24	0.0%	0.0%	0.0%	0.0%	0.0%	2.5%	9.4%	13.1	17.5	18.1	15.0	10.6	5.0%	3.1%	1.9%	1.9%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%
25-49	0.0%	0.0%	0.0%	2.7%	0.0%	0.0%	10.8	16.2	16.2	21.6	5.4%	16.2	2.7%	5.4%	0.0%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PMPM

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

PMPM Box Plot - 2nd Qtr Renewals

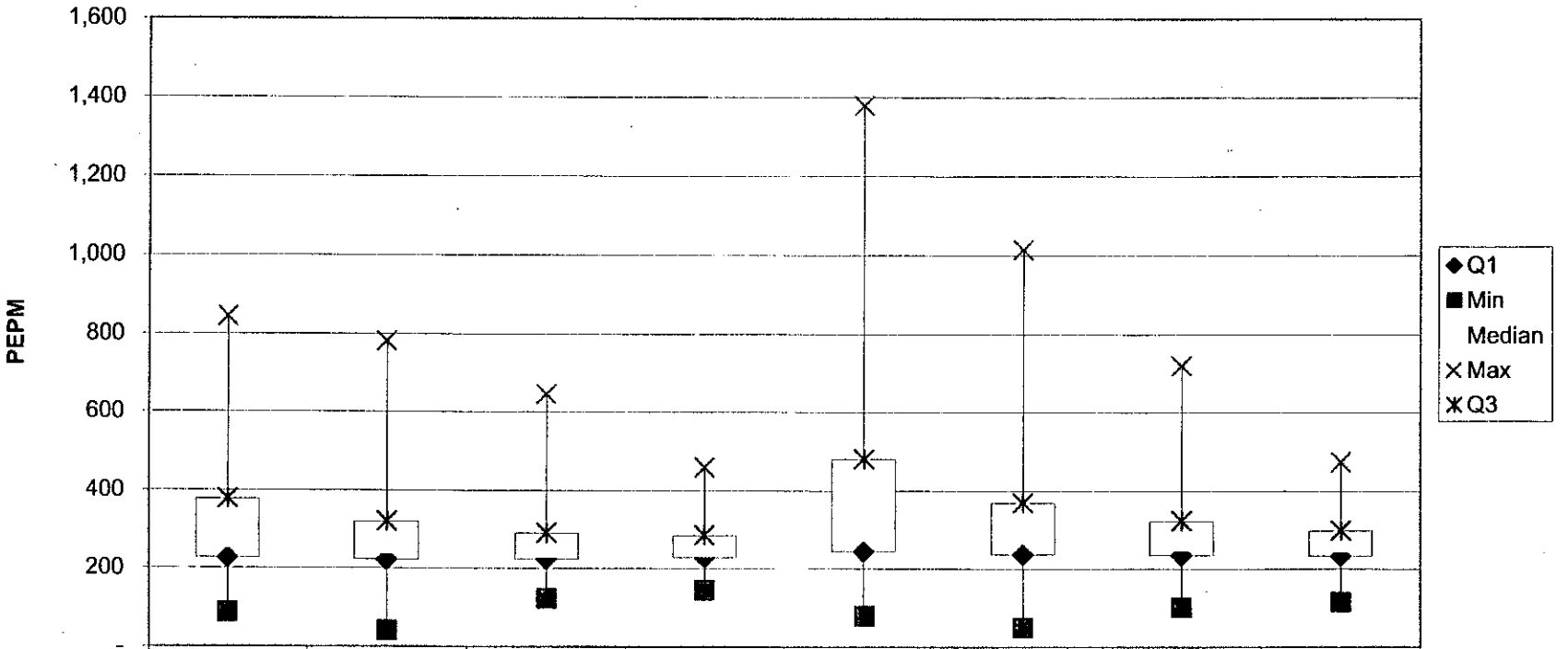


	2003 1	2003 2-9	2003 10-24	2003 25-49	2004 1	2004 2-9	2004 10-24	2004 25-49
◆Q1	227.45	227.74	231.27	244.95	247.48	230.89	235.31	232.43
■Min	91.59	40.08	121.28	183.40	78.09	77.49	146.53	113.84
Median	271.56	269.14	256.48	255.36	325.56	297.39	274.54	275.85
×Max	809.77	662.63	645.26	334.83	1,187.40	980.17	718.99	463.60
✱Q3	381.60	327.42	296.84	285.55	487.52	382.19	324.36	328.15

Group Market Segment

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

PMPM Box Plot - 2nd Qtr YTD Renewals



	1	2-9	10-24	25-49	1	2-9	10-24	25-49
	2003				2004			
◆Q1	226.42	221.51	223.20	227.66	243.59	235.66	234.76	233.18
■Min	85.90	40.08	121.28	143.13	78.09	47.89	100.53	113.84
Median	276.38	262.22	253.25	255.52	324.50	293.20	271.94	269.32
×Max	843.67	781.14	645.26	459.02	1,379.06	1,013.73	718.99	474.18
✱Q3	376.93	319.90	289.87	285.13	480.09	368.37	322.45	297.92

Group Market Segment

NH Insurance Department
August 2004
Source: Special Data Request to Carriers

Sept. 29, 2004

Litchko Consulting and Publishing
247 Tasker Hill Road
Conway, New Hampshire 03818

Phone 603-447-3591 Cell 603-662-8220 E-Mail Litchkodon@aol.com

29 September 2004

Subject: Statement and Request Concerning SB110 Revisions

Comments By: DJ Litchko, owner, Litchko Consulting and Publishing

BACKGROUND: In previous testimony before the Joint SB110 Oversight Committee I reported the impact of the revised Bill on my business and personal life --- Anthem BCBS increased my monthly premium 75%, from $1260 a month to $2209.00 per month; , Which equates to about one half of our normal monthly income.

STATEMENT Summary

Eight weeks ago I requested an explanation of the increase from Anthem BCBS and to date have yet to receive a response.

I asked the State of New Hampshire Insurance Department to secure the information for me and received a timely response from Mr. David Sky. A copy of that response is attached. Bottom line, according to Mr. Sky, is that 23.4 % of the increase was definitely attributable to SB110; an additional 32.7% was "potential attributable to SB110 and 41.8 % of the increase was attributable to Anthem.

I am providing this information as reference data for the committee to use when considering changes.

Mr. Sky further states that Anthem is likely to increase my premium an additional 18% next year – This would bring my premium up to $2606.00 a month.

REQUST:

Based on this likelihood and with the general knowledge that medical expenses in the United States increase in the order of 10 to 15 percent in year 2003 I am requesting this committee take action to;

Immediately instill a Maximum Cap on yearly increases; and that such a cap be based on the national average for medical expenses plus a small allowance for local variations.

And that the annual cap reverts back to year 2002 as a base, such that Small Businesses who employ 1-10 people, and are elderly will not be forced to accept an additional increase that far exceeds the national averages for years 2003 and 2004.

I further request that the committee take steps to allow and provide Small Independent Business Owners to join and band with larger groups for the mutual benefit of all. To consider a group of "one" as a group under the disguise of benefiting from Group Insurance is absurd.

Lastly; should the State ever consider forming a team of lay personnel to investigate and make recommendations for a long term insurance solution I would like to serve on such a committee – Not because I am an Insurance expert – but rather to provide a perspective from those of us who are not insurance experts and provide assurance that discriminatory aspects are addressed and eliminated.

Respectfully submitted and requested

Don Litchko
Owner, Litchko Consulting

The State of New Hampshire
Insurance Department
21 South Fruit Street Suite 14
Concord NH 03301-2430

Roger A. Sevigny
Commissioner

September 21, 2004

Mr. Don Litchko
Litchko Consulting and Publishing
247 Tasker Hill Road
Conway, NH 03818

RE: Request for Insurance Increase Explanation

Dear Mr. Litchko,

I have reviewed the components of your rate increase and have prepared the attached spreadsheet for your review.

Concurrent with the implementation of SB 110, Anthem made a number of other rating methodology changes. Anthem could have made these changes even if SB 110 had not passed. For example, prior to the implementation of SB 110, Anthem was not fully utilizing the full variation allowed for rating by group size. This factor may to vary from 1.2 to 1. Anthem is using a factor of 1.125, which is a 12.5% increase over last year. Anthem changed its rate ratios for rating couples versus singles, which increased your rate another 11%. Finally, Anthem changed from a no tier methodology to a block tier methodology, which increased your rate another 12.8%. These latter methodologies are strategies for allocating assessments to groups with varying ratios of dependents to employees. The portion of the increase attributable to these types of changes is approximately 42%.

SB 110 allowed for further variations. For example, Anthem applied a rating surcharge of 23.9% to your group based on the health status of the covered members. This was partially offset by the assigned industry factor. The culmination of newly allowed factors, including more varied age factors, resulted in an increase of another 23.4%.

The Department has been monitoring the increases groups are realizing since the implementation of SB 110. The new law introduced greater variation. After the transition, groups should generally expect trend. However, for your group, it seems that Anthem intends to increase rates an additional 18% next year. This is due to factors that were not fully realized in this first year of transition as the legislature had implemented a cap on the new allowed factors.

I did not find, during my review, that Anthem had violated any aspect of the new legislation.

The Department continues to work with policymakers on issues of affordability and insurance rating methodologies.

If you have further questions, please feel free to contact us.

Sincerely,

? David Sky

David Sky, FSA, MAAA
Life, Accident and Health Actuary

Litchko Consulting Publishing
2004 Rate Analysis

Anthem	1-Jul-03	1-Jul-04	Contribution to Increase
Base Rate	223.41	241.49	
Other Charges			
Pure Premium	223.41	241.49	
Admin Load			
Fixed	52.49	32.96	
Variable	0.069	0.08	
PMPM	296.35	298.32	0.7%
EE1	2.130	2.262	
Total	2.130	2.262	6.2%
Group Size	1.000	1.125	12.5%
Geographic	1.000	1.060	
Group Size of 1	1.000	1.100	
SIC	1.000	0.950	
Health Status	1.000	1.239	
Product	1.000	1.372	
Transition Cap		1.250	
Anthem Cap	1.00	1.162	16.2%
Step Up	1.000	1.128	12.8%
Rate Ratio	2.000	2.22	11.0%
All Factors	2.130	3.336	
Premium	1,262.44	2,209.11	75.0%
Attributable to SB110			23.4%
Potential Attributable to SB110			32.7%
Increase not attributable to SB110			41.8%

State of New Hampshire Insurance Department
September 21, 2004

Application for Health Insurance

Complete all sections in black ink (please print) and sign.

BasicBlue®
Arkansas Blue Cross and Blue Shield
An Independent Licensee of the Blue Cross and Blue Shield Association

1. PROPOSED INSURED (OLDEST PERSON TO BE COVERED)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY NO.	HEIGHT	WEIGHT
			Self					

2. PARENT/GUARDIAN (IF POLICY FOR A MINOR)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP

3. SPOUSE (IF APPLYING)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY NO.	HEIGHT	WEIGHT
			Spouse					

4. DEPENDENT CHILDREN (IF APPLYING)

In the RELATIONSHIP box below, please indicate **son, daughter, stepson** or **stepdaughter** beside each dependent's name. **IMPORTANT:** If any dependents named on this application do NOT reside with the proposed insured, we must also have the custodial parent's signature. See page 6 of this application. **Dependents age 19 to 23 must be full-time students.**

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY NO.	HEIGHT	WEIGHT

5. STUDENT INFORMATION [Dependent(s) Age 19 to 23] Must be full-time student(s).

DEPENDENT	SCHOOL ATTENDING	SEMESTER HRS.	EST. DATE OF GRADUATION
			/ /
DEPENDENT	SCHOOL ATTENDING	SEMESTER HRS.	EST. DATE OF GRADUATION
			/ /

6. PERSONAL INFORMATION

PROPOSED INSURED MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

PROPOSED INSURED RESIDENT STATUS: U.S. CITIZEN ☐ YES ☐ NO IF NO, PLEASE EXPLAIN _____

7A. BILLING ADDRESS (only for billing)

STREET			CITY	STATE	ZIP CODE

7B. MAILING ADDRESS* (if different from billing address)

STREET			CITY	STATE	ZIP CODE

*IMPORTANT: Confidential medical information may be mailed to the mailing address.

8. TELEPHONE INFORMATION

HOME PHONE NO.	BUSINESS PHONE NO.	BEST TIME TO CALL	
( )	( )	AM PM	☐ HOME ☐ BUSINESS

FOR HOME OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

I.D. NO.	GROUP NO..	EFFECTIVE DATE

9 HOUSEHOLD INFORMATION

A. Do all proposed insureds reside in the same household? ☐ Yes ☐ No

If no, provide reason: _____ Address: _____

B. Do all proposed insureds reside in Arkansas? ☐ Yes ☐ No

If no, provide reason: _____ Address: _____

10 PROPOSED INSURED'S EMPLOYMENT INFORMATION

EMPLOYER	JOB DUTIES

11 SPOUSE'S EMPLOYMENT INFORMATION (if applicable)

EMPLOYER	JOB DUTIES

12 CURRENT INSURANCE INFORMATION

NAME OF COMPANY	I.D. NO.	GROUP OR POLICY NO.

Will the coverage applied for replace or change your current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? ☐ Yes ☐ No

If yes, termination date: _____/_____/_____

13 PREVIOUS COVERAGE

Have any of the proposed insureds ever had coverage with Arkansas Blue Cross and Blue Shield, Health Advantage, USAble Administrators or First Pyramid Life? ☐ Yes ☐ No

If yes, termination date: _____/_____/_____ I.D. Number _____

14 MEDICARE INFORMATION

Are you or any dependent to be covered by this policy also covered by Medicare? ☐ Yes ☐ No

Persons covered by Medicare:

(1) _____ Effective Date _____/_____/_____ HIC # _____

(2) _____ Effective Date _____/_____/_____ HIC # _____

15 DRIVER'S LICENSE INFORMATION (age 15 and older)

Proposed Insured's Driver's License # _____ State Issued _____

Spouse's Driver's License # _____ State Issued _____

Dependent's Driver's License # _____ State Issued _____

Dependent's Driver's License # _____ State Issued _____

Has any person to be covered had:

a. his/her driver's license suspended or revoked? (a) ☐ Yes ☐ No

b. two or more moving traffic violations in the past two years? (b) ☐ Yes ☐ No

c. been convicted or charged with driving under the influence of alcohol or a controlled substance? (c) ☐ Yes ☐ No

If you answered "yes" to any of the above questions, you must provide the following information:

Name of person(s) and date of occurrence(s) _____

_____

_____

16 SPORTING OR HOBBY INFORMATION (age 15 and older)

Does any person to be covered intend to pilot a private aircraft or participate in sky or scuba diving; ballooning; motor vehicle, boat or snowmobile racing; mountain climbing; hang gliding, or any other hazardous sport, hobby or activity? ☐ Yes ☐ No

Name of person _____ Please explain: _____

Name of person _____ Please explain: _____

Name of person _____ Please explain: _____

17 EXPECTANT PARENT INFORMATION

Is any person to be covered, or a dependent of the proposed insured (whether applying for coverage or not), now pregnant or an expectant parent? ☐ Yes ☐ No

Name _____ Expected Delivery Date _____

18 TRAVEL OUTSIDE THE USA

Is any person to be covered planning to travel or work outside the USA within the next two years? ☐Yes ☐No

If yes, country_____ Reason for travel _____ Length of stay _____

19 TYPE OF COVERAGE

(Proposed insured must be age 18 or older to apply for coverage other than individual.)

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Family

20 BILLING MODE

☐ Monthly Bank Draft ☐ Quarterly ☐ Semi Annually ☐ Annually

21 OPTIONAL RIDERS

☐ Physician Office Visits — $35 encounter fee; $2,500 calendar year maximum. Excess charges not eligible under the Catastrophic Major Medical Program.

☐ Prescription Drugs — $250 annual deductible; 50% coinsurance up to a $2,500 calendar year maximum. Excess charges not eligible under the Catastrophic Major Medical Program.

IMPORTANT NOTICE TO PROPOSED INSURED

You have the option to select an alternative health insurance policy or health plan which is not subject to all of the state mandated health benefits normally required in insurance policies or contracts in Arkansas. Some examples of state mandated health benefits which may be rejected by you include maternity and newborn coverage, in-vitro fertilization, diabetes and pediatric preventative care. Please consult your agent as to which state health benefits are excluded in this policy. This alternative health insurance policy or contract may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits coverages than those normally imposed on health insurance policies in Arkansas. If you select this option, please consult with your insurance agent to discover the degree to which the alternative health insurance policy or contract does not provide health and medical benefits equal to those policies subject to state mandated health benefits. If you are eligible for a health insurance policy, your insurance agent may offer you an alternative health insurance policy or health plan not fully subject to state mandated benefits. This coverage contains no benefits for: psychiatric conditions; substance abuse; maternity care; obstetric care; complications of pregnancy; children's preventive care; low-protein, modified products used in the treatment of PKU; TMJ; and in vitro fertilization.

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation.

If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

If accepted, the insurance applied for shall not become effective until the date shown on the identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. Send no money now.

22. MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question answered "YES," circle the condition requiring treatment and give full details in the ADDITIONAL MEDICAL INFORMATION box below.

1. Has any person to be insured ever had or been told he/she had:
   a. asthma, allergies, bronchitis, emphysema, obstructive or reactive airway disorder, pleurisy, sleep apnea, or any disorder of lungs, bronchial tubes, or respiratory system? — 1. (a) ☐ Yes ☐ No
   b. epilepsy, convulsions, seizures, vertigo or fainting, paralysis, parkinsonism, neuritis, migraine headaches, or any disorder of the brain or nervous system? — (b) ☐ Yes ☐ No
   c. mental disease, nervous disorder, emotional problems, anxiety, depression, eating disorder, psychiatric treatment, counseling, drug overdose, or attempted suicide? — (c) ☐ Yes ☐ No
   d. high blood pressure, arteriosclerosis, heart attack, stroke, heart murmur, palpitation of the heart, chest pain or shortness of breath, or any disorder of the heart, blood, blood vessels or circulatory system? — (d) ☐ Yes ☐ No
   e. back pain, arthritis, arthralgia, fibromyalgia, chronic fatigue, rheumatic fever, gout or any disorder of the muscles, bones or joints? — (e) ☐ Yes ☐ No
   f. cataracts, glaucoma, nasal septal defect, sinusitis, tonsillitis, or any disorder of the eyes, ears, nose, throat or esophagus? — (f) ☐ Yes ☐ No
   g. gastric or duodenal ulcer, indigestion, colitis or irritable bowel syndrome, gastric bypass, gastric reflux, hernia, hepatitis, or disorder of the stomach, intestines, liver, gall bladder or rectum? — (g) ☐ Yes ☐ No
   h. diabetes, goiter or any other disorder of the thyroid, pituitary, adrenal, pancreas or other glands? — (h) ☐ Yes ☐ No
   i. renal stones, bladder stones, nephritis, albumin, sugar or blood in the urine, or any disorder of the kidneys or urinary tract, or male or female reproductive organs including prostate, ovaries or breasts? — (i) ☐ Yes ☐ No
   j. cancer, melanoma, leukemia, anemia, tumor, neoplasm, malignancy of any kind or disorder of the lymphatic system or skin? — (j) ☐ Yes ☐ No
   k. any existing injury, deformity, incapacitation, disease or condition not listed elsewhere? — (k) ☐ Yes ☐ No
2. Has any person to be insured, or a dependent of the proposed insured **(whether applying for coverage or not)**, ever been treated for infertility? — 2. ☐ Yes ☐ No
3. During the past 5 years has any proposed insured:
   a. consulted, been examined, or treated by any physician or practitioner? — 3. (a) ☐ Yes ☐ No
   b. had x-rays, EKG, or any laboratory test or study? — (b) ☐ Yes ☐ No
   c. had or been advised to have a surgical operation? — (c) ☐ Yes ☐ No
   d. been confined or treated at any hospital, clinic, sanitarium, or other medical facility? — (d) ☐ Yes ☐ No

ADDITIONAL MEDICAL INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary, sign, date and attach to the application.)

Question Number	Person Treated	Condition and Type of Treatment	Date Occurred	Date Recovered	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	

(Continued on page 5)

22. MEDICAL QUESTIONNAIRE (continued)

PRESCRIPTION INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary, sign, date and attach to the application.)

4. Is any proposed insured currently taking any prescription medication, or taken prescription medication in the last 3 years? 4. ☐ Yes ☐ No

If "YES," provide details in the PRESCRIPTION INFORMATION box below.

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	

THERAPY OR TREATMENT INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary, sign, date and attach to the application.)

5. Has any proposed insured received occupational therapy, physical therapy, speech therapy, or chiropractic treatments? 5. ☐ Yes ☐ No

6. Has any person to be insured ever:
   a. consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? 6. (a) ☐ Yes ☐ No
   b. used any addictive or non-addictive drug or substance except as provided by a physician? (b) ☐ Yes ☐ No
   c. been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS-related complex or Immune Deficiency Disorder? (c) ☐ Yes ☐ No

Person Treated	Number of Treatments	Condition and Type of Treatment	Date of First Visit	Date of Last Visit	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	

7. Have questions 1 through 6 been answered with respect to all persons to be covered? If no, explain_____ 7. ☐ Yes ☐ No

23. TOBACCO USAGE

Have you or any of the persons to be covered used any form of tobacco within the last 12 months? If yes, list name of person(s) below and type and amount of tobacco used per day: ☐Yes ☐No

Name _____ Type _____ Amount _____

Name _____ Type _____ Amount _____

Name _____ Type _____ Amount _____

24 PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be rejected. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. (3) In addition to other exclusions and limitations, NO ARKANSAS BLUE CROSS AND BLUE SHIELD BENEFITS WILL BE AVAILABLE FOR 12 MONTHS FOR THE TREATMENT OF ANY CONDITION WHICH EXISTED BEFORE THE EFFECTIVE DATE OF MY COVERAGE. (4) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (5) I agree any provider of medical services or supplies is authorized and directed to furnish Arkansas Blue Cross and Blue Shield, its agents or any of its subsidiaries, all records or copies thereof, relating to such services or supplies. (6) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (7) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company or any third party engaged by Arkansas Blue Cross and Blue Shield to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give Arkansas Blue Cross and Blue Shield, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid without time limit; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request; (f) and authorize the Office of Driver Services to release my traffic violation record to Arkansas Blue Cross and Blue Shield.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

25 SIGNATURE LOCATION (This application must be signed in the state of Arkansas.)

This application was signed in _____, Arkansas.
City

26 SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured's Signature **OR** Parent's/Legal Guardian's Signature **(If policy for a minor)**	X	Date Signed	
Spouse's Signature (if applying)	X	Date Signed	

If any dependents named on this application do NOT reside with the proposed insured, the custodial parent's signature is required.

Custodial Parent's Name **(please print)**			
Custodial Parent's Signature	X	Date Signed	

THIS SECTION TO BE COMPLETED BY SALES REPRESENTATIVE

To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? ☐Yes ☐No

SALES REP S.S. #	SALES REPRESENTATIVE'S SIGNATURE X	DATE SIGNED
AGENCY FEDERAL TAX ID # (if applicable	SALES REPRESENTATIVE'S NAME (please print)	

COMMENTS:

FOR HOME OFFICE USE ONLY

HOME OFFICE ENDORSEMENTS:

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

CareFirst BlueCross BlueShield

Group Hospitalization and Medical Services, Inc.
550 12th Street, S.W.
Washington, D.C. 20065

Application for Group Coverage with a Health Questionnaire

(Maryland Groups not Subject to Small Group Reform)

HOW TO COMPLETE THIS APPLICATION:

1. Please type or print clearly with ball point pen.
2. Complete all appropriate items, sign and date.
3. **Employer must complete if Section VI is answered.** Number of employees in group _____.
4. Please return your application Form to your Employer.

I. APPLICANT

Last Name	First Name	Initial	Social Security Number

Residence Address *(Number and Street)* *(City and State)* *(Zip Code-9position, if known)*

Sex ☐ Male ☐ Female	Date of Birth / /	Height	Weight	Home Phone ( )
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow(er)				Work Phone ( )
Employed By *(Firm Name)* Address				Group Number
Occupation		Employment Status ☐ Full-Time ☐ Part-Time		Date Employed / /

II. TYPE OF ENROLLMENT

CHECK ONE:

☐ New ☐ Coverage Change

III. TYPE OF COVERAGE

CHECK ONE:

☐ Self-Only Coverage

☐ Self and Spouse (Two-Party)

☐ Self and Child (Two-Party)

☐ Family

☐ Is coverage complementary to Medicare? If so, complete Section VI, Medicare Coverage.

IV. CHANGE TO EXISTING COVERAGE

Dependents affected by adds or deletes must be listed in Section V - Dependent Information.

Identification Number, if different from Social Security Number

_____

☐ *ADD* dependents(s) listed in Section V

☐ *ADD* spouse due to marriage on _____(Date)

☐ *ADD* child due to adoption on _____(Date) or appointed **legal guardian** by court decree dated _____.

(Note: Documentation of adoption or court-appointed legal guardianship must be provided.)

☐ *REMOVE* dependent(s) due to _____ (Reason)

on _____(Date)

☐ *CHANGE* address to that shown in Section I above

☐ *CHANGE* my name from _____to that shown in Section I above

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst, Inc.

V. DEPENDENT INFORMATION

	Name - (Last) (First) (MI)	Social Security No.	Date of Birth	Sex	Height/Weight	Relationship
Spouse			/ /	☐ Male ☐ Female		
Child			/ /	☐ Male ☐ Female		
Child			/ /	☐ Male ☐ Female		
Child			/ /	☐ Male ☐ Female		

COMPLETE ONLY IF DEPENDENT CHILD LISTED ABOVE IS AGE 19 OR OVER

Dependent Name (*Last, First, MI*)	Full-Time Student?	**IF YES, ATTACH STUDENT CERTIFICATION FORM**	Disabled?	**IF YES, ATTACH DISABILITY CERTIFICATION FORM AND SUPPORTING DOCUMENTATION**
	☐ Yes ☐ No		☐ Yes ☐ No	
Dependent Name (*Last, First, MI*)	Full-Time Student?		Disabled?	
	☐ Yes ☐ No		☐ Yes ☐ No	

VI. MEDICARE COVERAGE

☐ Check this block if any person listed on this application is eligible for or receiving benefits under Medicare. If you checked the block, please give:

Name_____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled
Medicare Claim No._____ Eligible for: ☐ Part A Eff. Date_____ ☐ Part B Eff. Date_____
Name_____ Reason for entitlement: ☐ Age 65 or older ☐ Kidney disease ☐ Disabled
Medicare Claim No._____ Eligible for: ☐ Part A Eff. Date_____ ☐ Part B Eff. Date_____

EMPLOYEE STATUS: (CHECK ONLY ONE BOX) ☐ Actively Employed ☐ Retired

VII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

☐ Check this block if any person listed on this application is now or has been enrolled within the last 31 days in health care or catastrophic coverage through a Blue Cross and/or Blue Shield Plan, a Health Maintenance Organization, another insurance carrier or Medicaid. Is this coverage currently in effect? ☐ Yes ☐ No
If Yes, will this coverage be continued? ☐ Yes ☐ No
If No, please provide cancellation date_____/_____/_____

1. Policy Holder's Name:_____ Date of Birth_____/_____/_____
2. Name and Location of Insurance Company:_____
3. Policy Number_____ Policy Covers: Policy Holder Only ☐ Two-Persons ☐ Family ☐
4. Effective Date of Policy:_____/_____/_____ (month / day / year)
5. Service(s) Covered:

A. Hospital Services	☐ Yes ☐ No	E. Dental	☐ Yes ☐ No
B. Physician Services	☐ Yes ☐ No	F. Eye/Vision Care Services	☐ Yes ☐ No
C. Major Medical (out-of-pocket expenses)	☐ Yes ☐ No	G. Mental Illness Services	☐ Yes ☐ No
D. Separate Drug Program	☐ Yes ☐ No	H. HMO	☐ Yes ☐ No

6. Is coverage through an employer or other group? ☐ Yes ☐ No
   If Yes, name of employer or other group:_____

VII. PRIOR COVERAGE / OTHER INSURANCE INFORMATION (continued)

7. Is this coverage under COBRA? ☐ Yes ☐ No Reason for cancellation: _____

8. To be completed if the natural parents live apart and provide medical coverage for their children. Please indicate relationship to children (natural mother, natural father, step-parent):

PARENT WITH COURT ASSIGNED RESPONSIBILITY FOR CHILD(REN)'S MEDICAL EXPENSES

_____ ***Parent's Name / Child 's Date of Birth***

_____ ***Relationship to Child / Child's Name***

PARENT WITH CUSTODY OF CHILD(REN)

_____ ***Parent's Name / Child 's Date of Birth***

_____ ***Relationship to Child / Child's Name***

VIII. HEALTH EVALUATION QUESTIONNAIRE

NOTE: Check with your Group Administrator before you complete Sections A, and B. This information may not be required.

Please answer the following questions listed in SECTION A and B regarding each person named in this application that you wish to enroll for coverage. **(If confidentiality is desired, please make arrangements with your Group Administrator.)**

CHECK EACH ITEM **YES** OR **NO** **PLEASE COMPLETE SECTIONS A and B.**

1. Have you or any family member named in the accompanying application had a physical examination within the past 5 years? ☐ Yes ☐ No

SECTION A – To the best of your knowledge and belief, has any person named in the accompanying application had within the last 5 years, or does such person now have, any of the following:

	YES	NO
(a) Cancer, tumor or other growth, (malignant or benign)	☐	☐
(b) Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus Seropositivity (Positive HIV test)	☐	☐
(c) Kidney stones, kidney or bladder condition, urinary frequency or burning	☐	☐
(d) Goiter, thyroid condition, diabetes	☐	☐
(e) Seizure disorder, central nervous system disorder, multiple sclerosis	☐	☐
(f) Substance abuse (drug or alcohol dependency, abuse or addiction)	☐	☐
(g) Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition	☐	☐
(h) Cataract or other eye condition	☐	☐
(i) Tuberculosis, lung condition, asthma, bronchitis	☐	☐
(j) Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition	☐	☐
(k) Heart condition, abnormal blood pressure (hypertension, or hypotension), rheumatic fever, cerebrovascular accident (stroke)	☐	☐
(l) (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition	☐	☐
(m) (Female) is currently pregnant; expected date of delivery:_____/_____/_____	☐	☐
(n) (Male) Prostate condition, reproductive system disorders, infertility	☐	☐
(o) Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder	☐	☐
(p) Sexually transmitted diseases	☐	☐
(q) Anemia, blood disorders	☐	☐
(r) Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition **NOT** listed above in items (A-Q)?	☐	☐
(s) Had any departure from good health not previously mentioned in this questionnaire for which treatment or advice may or may not have been sought?	☐	☐

VIII. HEALTH EVALUATION QUESTIONNAIRE (continued)

SECTION B - If you have checked "YES" to any part of SECTION A, for each block checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgery, and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's First Name	Section & Letter	Diagnosis or Condition	Duration Dates From To	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name.	Recovery Check only one box	
					☐ Full	☐ Partial
					☐ Full	☐ Partial
					☐ Full	☐ Partial

IX. PLEASE READ CAREFULLY - THIS SECTION MUST BE DATED AND SIGNED

IT IS UNDERSTOOD AND AGREED THAT:

(a) The statements and answers made herein are complete and correct to the best of my knowledge and belief, and are made to cause the issuance of, and to become a part of, the coverage for which I am applying. Should any statement or answers made herein change before the coverage becomes effective, I will promptly notify CareFirst BlueCross BlueShield (hereafter "CareFirst").

(b) The coverage will become effective according to your Group's eligibility guidelines following approval of this application by CareFirst.

(c) Should any statements or answers contained in this application be untrue (if such statements are fraudulent or material to the acceptance of this application), then the coverage may be cancelled by CareFirst, and its obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid under the coverage.

(d) The Subscriber shall repay to CareFirst the amount of any payment(s) made in error to the Subscriber on behalf of the Subscriber or any covered family member as the result of a claim.

(e) Any physician, nurse, hospital or other provider (hereafter " Provider") having treated or attended me or any of my family members listed on this application, and having possession of any records or information with respect thereto, is authorized and directed to provide such information or records to CareFirst upon request for the purpose of evaluation of this application. This authorization is valid for 30 months.

(f) If this application is approved by CareFirst, I authorize any Provider to forward to CareFirst information concerning medical, surgical, pyschiatric or psychological services or supplies provided to me or to any of my family members listed on this application for the purpose of review, investigation or payment of a claim. This authorization is valid for the duration of coverage.

(g) Depending on the terms of your Group's contract: (1) there is a specified waiting period which all participants must satisfy before benefits are available for certain conditions, unless waived by CareFirst, and (2) credit toward the waiting period may not be given under this contract for any prior coverage with CareFirst or any other carrier.

(h) A copy of this application is available to the Subscriber (or a person authorized to act on his behalf) upon request.

X _____ _____

Signature of Applicant ***Date***

☐ Re-sign and re-date below **ONLY** if block is checked.

X _____ _____

Signature of Applicant ***Date***

Joint Legislative Oversight Committee on Small Group Health Insurance Reform

Annual Report

November 1, 2004

Oversight Committee Membership and Meetings

Rep. John B. Hunt, Chairman
Rep. Paul D. Spiess
Rep. David R. Meader
Sen. Robert B. Flanders
Sen. Russell E. Prescott

The New Hampshire Legislature adopted SB 110 during the 2003 legislative session (Chapter 188, Laws of 2003). This legislation made a number of changes to the statute that regulates health insurance policies sold to small employers. As noted in the House Journal when the bill was adopted, the reforms in the law were "designed to bring more insurance companies and products back into the state and to make the small group health insurance market more competitive."

In addition to changing small group rating regulations, the new law required the Insurance Commissioner to issue report annually on certain specific factors in the small group market. The report must provide information about the distribution of rating factors being applied to small employers and summarize the rating factors utilized by health carriers in the preceding calendar year. The commissioner is further required to report on the types of health coverage being purchased by individuals and employers by geographic area. This report must include specific details regarding the type of coverage, including, but not limited to, co-pays, out-of-pocket maximums, network restrictions, and deductibles. These reports are to be based on information supplied by the health carriers by April 1 of each year.

In order to provide a forum for the legislature to monitor the effects of SB 110 with the assistance of the Insurance Department and the reports submitted by the Commissioner, the Joint Legislative Oversight Committee on Small Group Health Insurance Reform was established. The Oversight Committee became effective on January 1, 2004 and will remain in place for 5 years.

Adoption of SB 110 – Summary of Major Provisions

SB 110 was adopted after a considerable amount of debate. Proponents of the legislation expressed concern over the high cost of health insurance in the state of New Hampshire and the low number of carriers offering small group products. They felt that

the modified community rating law adopted in 1994 (SB 711) had driven insurers out of the state, reducing competition among carriers and leaving small employers with few choices for purchasing policies for their employees.

The basic concept behind SB 110 was to provide insurance companies with greater flexibility in setting rates for small businesses. This was to be accomplished with two primary changes to the 1994 law. The first major change was to redefine 'small employer' as having between 1-50 employees (rather than 1-100 employees). Shifting employers with 51-100 employees into the large group market meant that these businesses were completely removed from the requirements of the 1994 reforms and community rating. The second major shift in SB 110 was the increase in the number of rating factors. Prior to 2003, insurers were permitted to use only age and group size (within defined limitations) as rating factors.

Rating Reforms in SB 110

RSA 420-G addresses portability, availability and renewability of health coverage. The law regulates underwriting and rating practices in the small employer and individual markets. The major changes adopted in 2003 were:

- Changed the **definition of small employer** from an employer with 1-100 employees to an employer with 1-50 employees

- Increased the number of **rating factors** that can be used for determining rates for small employers

  Prior to SB 110 Modified Community Rating

  Carriers allowed to modify rates for age and group size with following limitations:

  - AGE, using age brackets (0-18, by 5-year increments from age 19-64, and 65+)
  - Maximum premium differential for age **3:1**
  - GROUP SIZE, highest factor for group size could not exceed the lowest factor for group size by more than 20%

  After SB 110

  Carriers allowed to use the following rating factors:

  - AGE, using age brackets (0-18, by 5-year increments from age 19-64, and 65+)
  - Maximum premium differential for age **4:1**

- GROUP SIZE, highest factor for group size could not exceed the lowest factor for group size by more than 20%; SB 110 added a provision that allowed an additional 10% differential
- INDUSTRY CLASSIFICATION, highest factor not to exceed lowest factor by more than 20%
- GEOGRAPHIC LOCATION, highest factor not to exceed lowest factor by more than 15%
- HEALTH STATUS

  may reflect health status of covered persons, claims experience of small employer or duration of coverage since health status last reported

  variation between highest and lowest rate charged not to exceed 25%

  any change in rate solely attributable to health status change upon renewal shall not exceed 15%

- **Rate increase protection** – carriers are prohibited from increasing the rate on a small employer policy renewal by more than 25% over the previous year. This limitation does not include increases based on a carrier's annual cost and utilization trends or changes in the age of covered persons. This limitation will be eliminated on January 1, 2005.

- **Rating for Groups in Transition** – groups with 51-100 employees (and therefore defined as a small group prior to SB 110 but as a large group with the adoption of SB 110) required to use a weighted average calculation for determining premium rates - up to 25% of rate based on the group's experience and at least 75% based on the carrier's large employer group. This requirement will be repealed on January 1, 2006.

Opponents to SB 110

Those that spoke in opposition to the adoption of SB 110 predicted that addition of new rating factors would lead to higher health insurance premiums for certain segments of the population. They feared that premiums would increase in the Seacoast and in the northern region of the state due to the higher cost of health care in those areas. They also feared that older and less healthy people would see dramatic rate increases due to using health status as a rating factor. Some warned that small employers might be tempted to discriminate against employees or potential-employees that belong to one of the higher risk categories. Others predicted that new carriers might enter the state as a result of SB 110 exclusively to 'cherry-pick' the younger and healthier groups.

Issues and Information Reviewed and Discussed

New Hampshire Insurance Department

The Commissioner and staff of the New Hampshire Insurance Department have served as a valuable resource to the Oversight Committee. To date, they have presented the following information:

A. Group Health Insurance Rating – presented by David Sky, Life, Accident and Health Actuary, NH Department of Insurance

There are three distinct approaches to calculating a health insurance rate that applies to each employee in a small business. The rate must somehow reflect the differing family composition that each employee brings to the group. The methods described in this presentation were: the No Tier Approach (rates based on each individual member), the Block Tier Approach (adds factors to account for varying family sizes within an entire block of business) and the Hybrid Approach (accounts for varying family sizes but only based on the families in the group being rated).

A carrier's choice of rating methodology can have a significant impact especially on small employer groups. Theoretically, carriers could change their methodologies each year but this is not likely to happen. Carrier representatives noted that it is expensive and disruptive to change rating methodologies.

The rate increases seen in 2004 are not all attributable to SB 110. Some of these increases are a direct result of the change in rating methodology used by the carrier. New Hampshire carriers changed their rating methodologies in 2004. Anthem changed from No Tier to Block Tier. Cigna changed from Block Tier to the Hybrid Approach.

B. Preliminary Data on the NH Small Group Market in 2004

Commissioner Sevigny and his staff have been working to collect objective data to assist the committee in its charge of assessing the impact of SB 110. The data collected to date is preliminary and that information has not been collected from every carrier. The information is based on data provided by the HMO's in the state which represents over 90% of the small group market. Further analysis is required to assure the accuracy of the data and consistency in reporting.

The department has submitted reports on small group health insurance renewal rates from the first and second quarters of 2004. These reports provide information on rate changes in a variety of forms. Information includes Per Employee Per Month (PEPM) and Per Member Per Month (PMPM) renewal rates. One observation that can be made in reviewing this data is that the groups with 1 employee and 2-9 employees have seen the greatest impact on rates since the adoption of SB 110. The impact seen is in the range of 10-30% rate increases.

The department also included a graph that breaks down the three major components of PMPM rates – medical costs, administrative costs and income. Medical costs are the largest component of the rate and in the last four years, medical costs have been increasing at a higher rate than the other two costs.

At the request of the Chairman, the department has also submitted data on the total number of covered lives that have been reported for the purposes of the collecting the assessment for the New Hampshire Health Insurance High Risk Pool under RSA 404-G.

Experience of a Group of One

Mr. Donald Litchko of Litchko Consulting and Publishing LLC, Conway, NH addressed the Oversight Committee at the July 13 meeting. He described his personal experience with a health insurance premium increase in 2004. Mr. Litchko is a 63-year old man who is self-employed. His group policy (group of one) covers himself and his wife. Mrs. Litchko is 61 years old and a 7 year survivor of cancer. Mr. Litchko reported that his premium increased 75% in 2004. His premium increased from $1,260/month to $2,207/month. He felt that this increase was based on age, health status and geographic location rating factors allowed in SB 110. He expressed the strong belief that SB 110 is discriminatory and adversely impacts those citizens who most need health insurance – the old and the sick.

With Mr. Litchko's assent, the Committee asked the Insurance Department to analyze his case.

Mr. Litchko returned to the September 29 meeting and presented an analysis of his premium increase which had been prepared by David Sky, Life Accident and Health Actuary. Mr. Sky broke down the 75 % increase as follows:

Increases attributable to Anthem that could have been made prior to the adoption of SB 110, examples:

Applied full variation allowed for rating by group size:	12.5%
Changed rate ratios for rating couples vs. singles	11%
Changed rating methodology from No Tier to Block Tier	12.8%
Net Impact:	41.8%

Increases attributable to SB 110

Application of health status rating factor	23.9%
Application of industry classification factor	-.05%
Net Impact:	23.4%

Increases potentially attributable to SB 110: 32.7%

He concluded his analysis with a statement that Anthem intends to increase premiums by an additional 18% next year. This is due to the provision in SB 110 that capped premium increases in the first year that the law was effective.

Reinsurance Pools

Mr. Karl Ideman of Pool Administrators Associated addressed the committee on the subject of reinsurance pools.

He described how reinsurance pools operate. Reinsurance risk pools are nonprofit entities that spread risk among all carriers in the market. The underlying principle is that the highest costs are concentrated among a few individuals and if these costs are spread among all carriers the additional cost per risk to any one carrier is small. Under a prospective reinsurance model, carriers transfer high risk individuals to the pool within 60 days of writing a new policy. The reinsurance coverage and claims reimbursement arrangement is transparent to both the employer and the employee.

Mr. Ideman stressed two points: 1) all reinsurance pools that have been established across the country have done some good and none have done harm and 2) none of the pools that have been established have gotten into financial difficulty.

Conclusions

Since the new provisions of SB 110 have only been in effect since January 1 of this year, it is too early to fully assess their impact. The committee is working to establish baselines so that as data continues to be collected there will be a basis for comparing further changes in the small group market.

The Committee has agreed that if adjustments need to be made to RSA 420-G to soften the impact on small employers most adversely affected by the new law, that these adjustments should be made. At this point such adjustments have not been identified or discussed at length by committee members. Some suggestions have been made by parties testifying before the committee and may appear in the upcoming session in the form of proposed legislation. Such suggestions include:

- Changing the maximum premium differential for age back to 3:1
- Adopting a permanent cap on annual premium increases
- Allowing small employers to join purchasing alliances with other employers

The Insurance Department is currently working on developing legislation that would help small employers with high premiums through an assessment paid by all carriers. This assessment will be modeled after the assessment paid by carriers to fund the high-risk pool in the non-group market. The committee anticipates working on this legislation in the upcoming session.

Respectfully submitted,

John B. Hunt /PS

Rep. John B. Hunt, Chairman

Attachments:

1. SB 110, final version
2. 2004 1st Quarter Renewal Report, Rate Variation Graphs
3. 2004 2nd Quarter Renewal Report, Rate Variation Graphs
4. Litchko rate increase analysis

Speakers

SENATE INSURANCE COMMITTEE

Date 03/18/03 Time 9:15 AM Public Hearing on **Bill # SB 110**

(1)

relative to small group health insurance coverage.

Please check box(es) that apply.

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☑	☐	☑ MOSTLY	THOMAS WELSCH	BROKER EATON & BERUBE INS. & CLIENTS
☑	☐	☑	LISA CARROLL	SMALL BUSINESS SERVICE BUREAU
☑	☑	☐	RAYMOND WHITE	NH ASSN OF INSURANCE AND FINANCIAL ADVISORS
☑	☑ with one exception	☐	BETH ROBERTS	HARVARD PILGRIM HEALTH CARE
☑	☐	☐	PAULA ROGERS	NH INSURANCE DEPT.
☑	☐	☐	ALEX FELDWEBEL	"
☑	☐	☐	LESLIE LUDTKE	"
☑	☒	☐	GEORGE BLANDELL	BROKER SELF & CLIENTS
☑	☐	☒	RICHARD WHITE	AGENCY/SMALL EMPLOYER PAST PRES NAIFA
☐	☐	☐		
☑	☒	☐	BOB NASH	INDEPENDENT INSURANCE AGENTS AND BROKERS OF NH
☐	☒	☐	JIM HATEM	STATE FARM
☑	☐	☑	YVONNE NANASI	ANTHEM BCBS
☑	☒	☒	SCOTT ZIKE and MIKE KELLEN	FORTIS HEALTH
☑	☒	☐	CLARISSE BOUCHER	UNITED HEALTHCARE
☑	☐	☐	SENATOR CHUCK MORSE	
☑	☑	☐	SENATOR EATON	
☑	☑	☐	SENATOR CLEGG	
☐	☐	☐		
☐	☐	☐		

SENATE INSURANCE COMMITTEE

Date 03/18/03 Time 9:15 AM Public Hearing on Bill # SB 110

#2

[redacted]

Please check box(es) that apply.

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☐	☐	☑	PAULA MINNEHAN	New Hampshire Hospital Association.
☒	☐	☒	Cindy Theberge	Risk Management
☐	☐	☒	DONNA CARDOSA	NEBA
☐	☐	☒	Randy Walker	Hannah House, Inc.
☒	☑	☐	BILL CARR	N.H. Business Council
☒	☑	☐	Philip Grisafi	M+M Assoc
☒	☑	☐	Tom Murtagh	Atlantic Plains
☐	Undecided	☐	Judith Shiffer	Parks Tuttle
☐	☐	☑	Martha McLeod	North Country Health Consortium
☒	☐	☐	PAULA ROGERS	NH Insurance Dept
☐	☐	☑	Richard Dwyer	Health Trust
☐	☐	☑	Dan McLeod	NH Automobile Dealers Assoc.
☐	☐	☑	Mary Ruppert	North Country Resident
☒	☑	☐	Sean Lynch	John Alden Health
☒	☑	☐	Angela Franklin	HIAA/Trustmark Statement
☒	☑	☐	Liz Murphy	Cigna
☒	☐	☐	Claire Hebert	Small business owners
☒	☑	☐	DICK STONNER	SIR SPEEDY PRINTING / NFIB-NH
☐	☑	☐	John Cahill	Northstar Marketing
☒	☑	☐	Rep. Mark Carter (10 mins)	District 44

SENATE INSURANCE COMMITTEE

110

Date 03/18/03 Time 10:00 AM Public Hearing on Bill #~~SB 110~~

relative to scheduled permanent impairment awards under workers' compensation.

Please check box(es) that apply.

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☒	☒	☐	Peter Martin	Self
☒	☐	☐	Kipp Cooper	NHAR
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

SB 110

Speak?	For	Against	Name
	X		Rep. Robert J. Letourneau Need a little work
	X		Rep. Rogers Johnson
X	X		Mary Atwood

Please add Andy Dillman, representing NH High Tech council to speak.

Sen. Flanders

Please / Add:

Margie McClellan - opposition - to Speak from Berlin

Sen. Martel

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: March 27, 2003

THE COMMITTEE ON Insurance

to which was referred Senate Bill 110

AN ACT relative to small group health insurance coverage.

VOTE: 4-1

2003-0993s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Russell E. Prescott
For the Committee

SB110 Docket

Next|Prev|Results List|Main|Bill Status

Bill Title: (New Title) relative to small group health insurance coverage and relative to health plan loss information.

Date	Body	Description
1/30/2003	S	Introduced and Ref. to Insurance; SJ 3, Pg.35
2/4/2003	S	Hearing; ==== CANCELLED=== March 11, 2003, Room 101, LOB, 9:15 a.m.;SC8
2/7/2003	S	Hearing; ==== RESCHEDULED ==== March 18, 2003, Room 101, LOB, 9:15 a.m.; SC9
3/28/2003	S	Committee Report; Ought to Pass with Amendment{0993}, [04/03/03]; SC16, Pg.25-26
4/3/2003	S	Committee Amendment{0993}, AA, VV; SJ 11, Pg.252-253
4/3/2003	S	Sen. Prescott Floor Amendment{1134}, AA, VV; SJ 11, Pg.253
4/3/2003	S	Ought to Pass with Amendments,{0993},{1134}, RC 15Y-8N, MA: OT3rdg; SJ 11, Pg.253-254
4/3/2003	S	Passed by 3rd Reading Resolution; SJ 11, Pg.265
4/8/2003	H	03/26/2003 Introduced and ref to Commerce; HJ34, p1086
4/8/2003	H	Hearing Apr 23 1:15 RMs302-304,LOB
4/24/2003	H	Subcom Work Session Apr 30 10:00 RM302,LOB
4/30/2003	H	Subcom Work Session May 6 1:15 RM302,LOB
4/30/2003	H	(Subcom: Reps Hunt, Fraser, Brady, Kathleen Taylor, Spiess & Kopka)
5/6/2003	H	Subcom Work Session May 13 10:00 RM302,LOB
5/13/2003	H	Subcom Work Session May 15 after session RM302,LOB
5/15/2003	H	Subcom Work Session May 20 11:00 RM302,LOB
5/20/2003	H	Maj Report OTP/AM for June 5 (Vote 10-8;Reg)
5/20/2003	H	Min Report ITL
5/20/2003	H	Prop Maj Am{1713}(New Title); HC 44, p1428-1432
6/5/2003	H	Comm Maj Am{1713}(NT), AA DIV(204-143); Passed with Am RC(202-161); HJ 47, p1501-1507 + 1514
6/5/2003	S	Sen. Flanders Concur with House Amendment, MA, VV; SJ 19, Pg.646
6/24/2003	S	Enrolled; SJ 20, Pg.828
6/24/2003	H	Enrolled;
6/30/2003	S	Signed by the Governor on 6/30/2003 Eff- 9/1/2003* Chap- 0188
6/30/2003	S	*Multiple Effective Dates, See Chapter, Sec. 18 for additional dates

Next|Prev|Results List|Main|Bill Status

Docket Abbreviations