

**THE INSURERS' PERSPECTIVE ON
THE HEALTH CARE SYSTEM,
INSURANCE AND THE UNINSURED**

By

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The State of New Hampshire has always recognized that a solution to the uninsured must involve private insurance carriers and health plans. In order to incorporate these perceptions and insights into the HRSA project, Bruce Spitz and Deborah Chollet¹ conducted a series of comprehensive, structured interviews with representatives of the four major insurers in New Hampshire:

1. Rod Turner, Vice President for the American Republic Insurance Company (Republic).
2. Brian Wells, President and General Manager for CIGNA HealthCare (Cigna).
3. Gray Somers, Vice President and General Manager for Anthem Blue Cross Blue Shield of New Hampshire Inc. (Anthem).
4. Beth Roberts, Director, NH Operations and Development, Dr. Alan Freeman, Associate Medical Director, Dr. David Cochrane, Senior Vice President of Strategic Development and Denise McDonough, Sales Manager, for Harvard Pilgrim Health Care of New England (Harvard).

The interviews were conducted in February 2002. The insurers were told that the purpose of the discussions was to make them a part of the HRSA study and include their observations, experiences and perceptions on the:

1. The structure of the New Hampshire health care market
2. The cost of health care and insurance in New Hampshire.

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3. The factors they thought affected the decision to purchase health insurance.
4. Options for reducing the number of individuals without insurance.

The interview process was fluid and conversational. While all the questions were asked, the order in which they were asked invariably changed and issues that were not explicitly raised in the questionnaire were also discussed. (See Appendix A. Insurance Questionnaire). Further, since none of those interviewed saw the questions prior to our meetings, some of their responses were based on their estimates and sense of what was occurring, and not on data they had collected for our discussions. In general, the insurers' responses reflected the products they sell in New Hampshire's health insurance market.

The Individual and Non-group Markets

American Republic Insurance Company of Iowa, a national insurer that specializes in non-group insurance, serves approximately 6,000 of the 20,000 individuals who purchase non-group insurance in the New Hampshire market. Compared to the three large group insurers in this survey (Anthem, Cigna and Harvard), Republic offers a product with:

1. Relatively higher administrative costs than the other plans interviewed. Thirty five to forty percent of the premium dollar is allocated for administrative functions, such as marketing and servicing the product, compared to 16.5 percent or less of the premium dollar for the large group insurers.²

² This was Republic's estimate of the administrative costs incurred by non-group insurers. Republic did not provide the specific proportion of their costs that are administrative. We are assuming that Republic's administrative costs fall within the range of costs that it suggested is common among non-group insurers.

2. Relatively higher deductibles (their current products for new enrollees have \$2,000 deductibles whereas the large group carriers typically offer insurance with \$500-\$1,000 deductibles)
3. Reliance on indemnity coverage.
4. No provider discounts on prices or charges. Republic is currently interviewing prospective PPO networks for the purpose of “renting” a discount network. Negotiated discounts have been one of the more effective methods that the large group insurers have used to reduce their costs.
5. No attempt to control patient utilization or provider behavior through managed care or point-of-service products.

The Large Group Market

Anthem, Cigna and Harvard are the principal large group health insurers in New Hampshire. Anthem and Cigna sell coverage throughout the state, while Harvard concentrates its business in southern New Hampshire. In 2001, Anthem represented 242,069 lives or 55.9 percent of the privately insured individuals in the State’s large group market. Cigna represented 154,157 lives (35.6 percent of the privately insured large group market) and Harvard represented 23,218 lives (5.4 percent). Neither Cigna nor Harvard provided non-group insurance. Anthem and Cigna insure individuals throughout the State. Harvard only provides coverage in the more densely populated Southern portion of the State.

All of these large-group insurers negotiate discounts and reimbursement arrangements with providers. All use utilization review of some sort. Cigna and Harvard offer products that either provide beneficiaries with financial incentives to use less expensive providers or that exclude expensive providers from their networks. Harvard specializes in managed care products that rely on monitoring or requiring adherence to medical protocols, although they admitted that in actuality they have only limited impact on how providers diagnose, treat and refer.

Common Themes

Although the insurers' responses differed somewhat based on their market share and product lines, they voiced a number of common themes:

1. The insurers said they believe the current rate of increases in health insurance premiums is probably not sustainable. They did not specify when the "bubble" would burst, but all said that the current rate of increase is worrisome.
2. They also said they may have reached the limits of what they can do to control costs by negotiating price discounts.
3. Their ability to maintain their existing utilization controls - let alone impose more stringent controls - has met with strong beneficiary, employer and media resistance.
4. Each individual insurer has had difficulty imposing their specific treatment protocols on providers because of the lack of uniform disease treatment protocols (e.g., treatment of diabetic or asthmatic patients) across all insurers; the product of resistance on the part of medical professionals to paradigms imposed by insurers,

- provider reluctance to adopting different protocols for the same disease and the public and media resistance to managed care in general.
5. Similar to number 4 above, the insurers said that the public does not want significant limitations placed on their choice of providers or the services that are covered. Most employers and patients, they said, are unwilling to accept an insurance product with a restricted (or selected) group of providers.
 6. The large group insurers referred to John Wennberg's work on the variation of physician practice patterns within similar populations, but none of the insurers said they know exactly how to use that information to control costs.
 7. For the most part, the insurers said they believe the most effective way left to control costs is to make the patient more directly responsible for the cost of obtaining medical care by increasing their first-dollar financial exposure (e.g., deductibles, coinsurance and co-pays).
 8. All insurers felt it is more difficult to control costs and function in the non-group market than the small or large group markets.
 9. In general, the insurers do not believe that increasing the number of carriers selling health insurance is a solution to the problem of rising premiums. Anthem, Cigna and Harvard raised concern that the opposite effect might occur. More competing insurers might raise costs by diminishing their negotiating clout with physicians, hospitals and suppliers. Republic said they believe the non-group market should have at least 10 insurers to make it competitive, while the large group insurers believe that 3 insurers is probably ideal.

10. All of the insurers said they are willing to work with government to craft solutions. However, all were distrustful of additional costs that government might create through additional mandates, regulations or reporting requirements. Nonetheless, if solutions could be created that imposed uniform burdens across all insurers, then they were more than willing to work cooperatively to create a less expensive product. Most of the insurers indicated that a regional solution engaging all three Northern New England states could be very promising.

System Characteristics: The Structure and Cost of the Health Care Market

Physicians and Hospitals. In 1998, the Department of Health and Human Services, the Insurance Department and the Attorney General's Office began working jointly to implement a State health plan. Part of that project has involved gaining a more detailed understanding of the nature and operation of the health care market. Initial studies have involved financial and economic analyses of the state's hospitals and community health centers. The analysis of the health plans and insurers is underway. In 2001, the legislature asked the Attorney General's office to examine the financial and legal relationships that existed between physicians and hospitals. To complement both the completed hospital economic analysis³ and Attorney General's physician hospital analysis, we asked the insurers to estimate the percentage of participating primary care

³ Nancy Kane, *Analysis of Health Care Charitable Trusts in the State of New Hampshire: The Hospital Sector*, submitted to the New Hampshire Department of Health and Human Services, December 2000; Boyd Gilman and Jerry Cromwell, *Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals*, Waltham, MA, Center for Health Economics Research, 2000.

physicians and specialists that were controlled by Physician Hospital Organizations (PHOs), hospital employment or other hospital arrangements.

The insurers have mixed perceptions on the impact of hospitals on physicians. Republic does not negotiate discounts with providers and therefore was unaware of the specific financial relationships between hospitals and providers. Harvard believes that hospitals controlled 80 percent of the physicians in New Hampshire – a perception that could have mirrored the nature of the contracts that Harvard preferred to write (that is, managed care contracts with local integrated hospital physician delivery systems), as well as the fact that Harvard only deals with providers in the Southern part of the State. Cigna and Anthem estimate that hospitals exert control over 20 to 30 percent of the primary care physicians and a much smaller percentage of the specialists. They also said they feel that physician hospital organizations are not the primary channel through which hospitals influence physician behavior. Instead the hospitals' control occurs primarily when they employ physicians directly within the hospital or have purchased the physicians' practices. No numbers were given to document the number of physicians actually employed by hospitals that these plans currently contract with. Thus, based on these interviews it is not clear how important this factor is in the state's health care market. However, Anthem did say their impression is that hospitals might have overstated their influence on physician behavior. In their words, the hospitals "think they have more control than they do."

The large group insurers identified the North Country and the Seacoast as the most problematic parts of the State to establish a network and negotiate with physicians. Cigna noted that one physician group in the Littleton area objected to capitation; when Cigna switched to a statewide fee-for-service arrangement, the physician group objected to that as well. Similarly, Cigna indicated that it had needed to pay an Exeter physician group a higher fee schedule in order to get them in the network. According to Cigna, “The employers wanted them in the network, so we didn’t have a choice.”

According to the insurers, physician self-referrals within multi-specialty physician groups have not posed a significant problem to their patients. The insurers felt the referral practices are consistent with behavior that existed prior to managed care and capitated arrangements. Physicians are always inclined to refer to other doctors with whom they have pre-existing, trusted relationships. Despite the fact that beneficiaries have complained to legislators and State agencies, the insurers stated that they had not received complaints from beneficiaries about these practices. Harvard felt that these referral networks are actually beneficial. For example, Harvard noted that working with the Dartmouth-Hitchcock physician group offers patients a higher quality product and at reasonable cost.

Costs. Historically, New Hampshire had been one of the insurers’ lower cost New England states. Now, New Hampshire is Republic’s and Cigna’s most expensive state nationwide. Republic expects this to change once the high risk pool is established and the rating methodology changes in July, 2002. Anthem and Harvard noted that Maine is

more expensive for them (although Harvard's New Hampshire costs are influenced by the fact that it primarily operates in the relatively lower cost Southern region of New Hampshire and does not contract with Exeter Hospital, which is one of the more expensive hospitals in the State). Three of the insurers said the North Country and the Seacoast are the most expensive regions within the State.

During these interviews none of the insurers singled out inpatient hospitalization as causing an unusual increase in expenditures. Instead, the insurers identified outpatient care and the cost of pharmaceuticals as the primary cost culprits. Cigna indicated that pharmaceuticals now account for a greater portion of their costs than hospitalization.

New technology has been a principal cost driver for medical services. However, none of the insurers said they review their costs under the category of *New Technology*. New procedures and interventions can be and are identified by new CPT and ICD-9 codes, and some of these costs are tracked. The insurers also said they examine spikes in utilization and “drill down” to determine specific causes.

The most detailed discussion that we had on new technology was with two physicians from Harvard. They suggested that restricting our attention to a new intervention or equipment alone would inevitably under estimate the impact that new technology, new knowledge and new marketing techniques have on the cost of medicine.⁴

⁴ Since this is a topic of interest for this project, we have elaborated and expanded upon that exchange. A more appropriate review of the impact that new technology is having would also include effects of:

Competition. American Republic hypothesized that the State needs at least 10 competitors (6 strong plans and 4 “niche” players) in order to produce effective competition in the non-group market. The question is what kind of efficiencies would be realized and what kind of cost reductions would consumers experience if there were an additional 9 plans competing for the 20,000 lives in the nongroup market - particularly if Republic maintained its 6000 clients? The remaining plans would be competing for 14,000 individuals or approximately 1,555 enrollees per competitor. This number is so low that it could discourage competition. Republic indicated that if it had less than 1500 beneficiaries and no other business in a region, it would consider exiting that market. It should be noted that even if Republic did not maintain its share of the market, ten insurers competing for 20,000 lives would, on average, hover just above the 1500 beneficiary threshold.

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1. Expansion of the definitions of illnesses. Over time, the definitions of common medical conditions – more specifically the threshold for those conditions - changed, become more demanding and consequently included more individuals (e.g., high blood pressure or high cholesterol).
 2. Screening creep. The frequency that the test should be given and age and medical conditions of the individuals that should be screened for specific diseases has also tended to change and expand the number of individuals affected. The result is often that more people are examined more frequently. Screening carries the danger of false positive results as well as the discovery of non-lethal abnormalities. Both conditions can prompt further tests, medical interventions and costs.
 3. Application Creep. Technology that was designed for a highly specific purpose has been applied to conditions that it was never intended to examine or cure. The MRI, for example, is a minimally invasive diagnostic marvel that was originally designed to reveal critical information about hard to reach soft tissue (e.g., the brain). Now MRIs are being used to provide full body scans or review the conditions of arthritic knees. Each new application adds to the cost of health care.
 4. Demand creep. New technology can solve a medical condition. New marketing techniques can also create the demand for goods and services that may have an inordinately small marginal benefit but add considerably to the cost of care. Some critics have argued that direct, mass marketing for prescription drugs is an example of this type of demand creation.

Republic noted that competition would spur efficiencies in claims administration (particularly if nongroup insurers moved to electronic processing of claims) and servicing beneficiaries (e.g., through interactive websites). Competition would also prompt differences in the quality of customer service. Republic did not feel that relative savings could be generated through provider price discounts (that is, even if Republic rented a local PPO, there would be a high likelihood that other nongroup carriers would rent the same PPO) or utilization controls. Republic noted that the lack of control over provider prices could easily negate any administrative savings.

In general, the large group insurers do not think that increased competition in the form of adding more health plans in the state will lead to a solution for the problem of rising medical costs or the uninsured. They believe the problem is not due so much to their administrative inefficiencies (the only factor of production they have direct control over), but their inability to exact greater savings in the form of provider price discounts or utilization controls, and the consumers' (patient and employers) unwillingness to buy products with restricted provider panels or strong controls on patient utilization.

The large group insurers were not as sanguine about the benefits of competition. They felt that three competitors were ideal. Three competitors can keep each player honest in terms of the conditions that they demand from employers, patients, and providers. Also, the presence of three health plans – as Anthem noted – gets any one insurer “out from under the microscope” of constant public review and inspection. If the number of competitors increased to more than 3 then the ability for each individual competitor to

negotiate price discounts or gain provider compliance with any case-management requirements would be markedly diminished.

Lowering Insurance Premiums

A central part of the interviews concerned the actions that insurers could take to produce a lower cost insurance product. Most said they believe the current medical prices increases are unsustainable but they feel they may have reached the limits of what they can do to control costs.

The large group insurers are familiar with the financial and economic analyses on the hospital sector that the State commissioned. One report found that most of the hospitals were financially stable, comparatively profitable and offered very limited discounts to commercial payers.⁵ Another report indicated that the hospitals' average costs and net revenues per admission were low (compared to other New England states) and that competition between the hospitals was very limited.⁶

The insurers indicated that the strong position of the hospitals made it difficult to demand deep discounts and that it is unlikely that they will be able to negotiate significant discounts in the future. The insurers also indicated that physicians and other providers expect their rates to increase at least at the rate of inflation and more often at the higher medical care component of the consumer price index. Rising costs therefore had an

⁵ Nancy Kane, *Analysis of Health Care Charitable Trusts in the State of New Hampshire: The Hospital Sector*, submitted to the New Hampshire Department of Health and Human Services, December 2000.

⁶ Boyd Gilman and Jerry Cromwell, *Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals*, Waltham, MA, Center for Health Economics Research, 2000.

inexorable quality that was compounded by the insurers' inability to penetrate other aspects of medical care.

In addition to rising provider prices, insurers noted difficulties controlling utilization. In recent years, beneficiaries, employers and politicians have displayed strong opposition to utilization limits. The insurers noted there has been an attack on managed care in the media. And, the lack of uniform disease treatment protocols (e.g., treatment of diabetic or asthmatic patients) across insurers make it difficult for any single insurer to have their protocol adhered to. In addition, the public does not want significant limitation on their choice of providers. Therefore, most employers are unwilling to purchase an insurance product with a restricted (or selected) group of providers. All of the large group insurers referred to Jack Wennberg's work on the variation of physician practice patterns within similar populations, but none knew exactly how to use that information to control costs. Employers might inform employees more fully about the total cost of health care through reporting premium payments on their pay stubs, providing a complete explanation of benefits after bills are paid, or holding seminars on medical costs. Some insurers thought this might be useful. Others were less optimistic. Harvard noted that "in Canada they sent out dummy bills, but it didn't matter." One executive speculated that once employees understand how much money is being spent for their insurance premiums they might be spurred on to use as many services as they can.

Increasing First-Dollar Patient Costs

For the most part, the insurers said they believe the most effective way left to control costs is to make the patient a more direct part of the purchasing decision by increasing the patient's first-dollar financial exposure (e.g. deductibles, coinsurance and co-pays). This would "unshield" the patients from the economic implications of their utilization. This could be done by either increasing specific financial levers: hiking co-pays to reduce office visits, offering catastrophic coverage that held the patient responsible for everything but high cost care or adopting some form of a Medical Savings Account. The concern was raised that these policies have a potential negative effect if individuals refrain from seeking out and receiving needed medical care. The insurers also raised some concern that the healthy and more affluent might purchase lower coverage options leaving the sick and less affluent with higher premium costs for comprehensive coverage.

The Cost of State Regulations

Insurers felt that insurance costs could be reduced if government mandates, regulations and reporting requirements were minimized. All of the insurers questioned the wisdom of some mandates, but few specific illustrations were offered. Republic cited a national study indicating that mandates account for between 15-40% of insurance costs. Republic also suggested that the State should avoid mandating additional benefits and possibly make the mandates optional for the individual market. In that case, the individuals that were both paying for and using the policy could decide what benefits they wished to purchase and insurers could write policies that met specific needs. Cigna was also cautious about the need for mandating benefits indicating that while mandates should not

be completely eliminated the State should carefully review and reconsider them. As an example, Cigna cited that the State still mandated coverage for bone marrow transplants for women with breast cancer even though this procedure has been proven ineffective.

There were four common objections to regulations. First, there are regulations that award special privileges to providers. As Cigna observed, “The legislature should not be the bargainer for providers. We have a prompt pay mandate of 15 days. Why does a medical provider have to be paid in 15 days when the plumber waits 30 days?” Harvard objected to limitations imposed on retroactive claim adjustments. “We have 90 days to file a claim and now only 90 days to adjust it for eligibility. We are not able to deny a claim after its paid even if the patient was not eligible for benefits. The providers won this regulation by saying their claims for payment were being denied. But, let’s say we paid the bill for a person who was no longer eligible under our plan. They switched employment so that Anthem got the premiums, but we paid the bills.”

Second, they objected to regulations that promote adverse selection. The insurers were not objecting to guaranteed issue or modified community rating (because of the change in the insurance law. Even with that change, Republic would have liked to have greater leeway to set its rates). Insurers disliked the fact that different rules apply to the non-group market and the one-person small group insurance market. Harvard said that they have “a special problem with the one-person group, including the high-risk pool, where individuals buy insurance who know they will need medical care. An individual will incorporate just to buy group health insurance, so we get the high cost cases.” The

feeling expressed is that the rules governing the non-group and one-person small group insurance policies should be the same.

Third, insurers objected to regulations that impose costs but appear to yield little benefit to anyone. For the most part these objections were directed at the frequency of reporting requirements and obtaining approvals (e.g., the need to request approval for every rate increase rather than allowing insurers to work within a range of approved rates) or the nature of the reporting requirements (e.g., a recent demand that the insurers report at the zip code level, a requirement that is expensive and whose use is not clear to the insurers).

Finally, some regulations required insurance companies to fund functions that benefited everyone in the state (those using insurance products as well as those who do not use insurance products) but whose costs were borne primarily by the insurance companies. Harvard indicated that in New Hampshire it has to reserve 17% of its premium dollars for programs like immunization, assessments for running a state agency, the high-risk pool and mandates.

The Decision to Purchase Care

The rate that individuals and families disenroll, i.e. let their insurance lapse, appears to be heavily related to the type of insurance they buy and to a lesser extent product loyalty. Republic indicated a much higher lapse rate than the other insurers with a disenrollment rate of 35-40% in the first year. During the second year, the lapse rate falls to 25 to 30 percent, the third year to 20 percent and approximately 15 percent thereafter. In part this reflects the transitional function that non-group insurance plays – a form of bridge

insurance for individuals between jobs or other sources of coverage (e.g., people taking early retirement who are not yet eligible for Medicare). At the other extreme Harvard claimed that no more than 2 percent of their beneficiaries disenroll. Anthem indicated only a 5 percent lapse rate percent.⁷

When premiums rise rapidly, individuals and employers can attempt to limit those premium increases by either reducing the benefits that are covered or increasing the patient's financial obligations (e.g., higher deductibles, coinsurance and co-pays). The cost reductions have primarily taken the form of increased patient payments and - when available – increased reliance on HMO and point-of-service arrangements. These efforts to “buy down” the premiums have been occurring for some time. Republic noted that it was a 30-year trend that had not accelerated. Cigna observed that, “at every renewal, our customers are asking how they can reduce premium costs. We suggest buy-downs as a way to keep business....The brokers are asking for higher deductibles. Employers rarely drop a benefit entirely, but choose cost shifting options through re-structuring the plan's co-pays, for example increasing drug coverage from \$5 to \$15, setting co-pays at \$10, \$20 and \$40 per provider visit or shifting the co-pay on mental health visits so that the first 10 visits cost less than the second 10 visits.” Harvard indicated that they are “nervous” about buy down trends because they might financially isolate the 5 percent of the population that accounts for 50 percent of the health care expenditures. In this setting, the monetary contributions the healthy make for those who are ill decrease,

⁷ Republic only offered non-group insurance. Cigna and Harvard only offered group insurance. The differences in the lapse rates might reflect different ways of counting that rate e.g. covered life lapse rates versus group lapse rates.

thereby potentially making the first-dollar coverage prohibitively expensive for some people.

New Insurance Products

The discussion of new products focused on what currently exists, what might be created for the general public and what might be targeted to the low-income uninsured population. Two general products were examined. Both would involve working with State government.

The first area of questions asked insurers whether they might be willing to join the state in bulk purchasing pharmaceuticals, eyeglasses, medical devices or other goods and services. The rationale is that large purchasing entities might realize greater savings and discounts from manufacturers. The second set of questions inquired into the more novel idea of whether insurers would be interested in bidding on a large block of business based on the pool of State and municipal employees, Medicaid, Worker's Compensation, etc. The structure of the program was left relatively open with regard to whether this meant administrative services only or includes underwriting risk, but there were two provisos:

1. The winning company(s) would offer state and local government products at the same or lower costs than currently exists.

2. The companies had to offer insurance products to all the residents in the State at a lower cost than was currently available in the non-group and small group markets.

This arrangement would **not increase** State costs or financial obligations and would help restructure and reduce costs in the broader market by giving individuals without employer coverage access to insurance products with lower administrative costs and higher purchaser discounts. The advantage to the insurer is that the system would be more lucrative and less volatile than the current non-group market.⁸

Bulk Purchasing Arrangements. The bulk purchasing proposal evoked positions that ranged from interested (Cigna's stated that this might be an extension of what managed care companies, the CDC and the State already do with the vaccine program) to interested but skeptical. Some insurers' were wary that the State would create onerous administrative requirements. Republic stated that it would join the State, "as long as it works with our administrative processes. We'd be interested in working on this on a multi-state basis with Vermont, New Hampshire and Maine. We'd be interested in selling the same product in three states. It's a shame the momentum to get this going died. We would need an agreement on reciprocity for rates and licensure, although this might not have to be with one governing body.... We would work with the states even if it involved administrative changes, as long as the changes are positive and reasonable with regard to our business."

⁸ Bruce Spitz of the Spitz Consulting Group and Harry Pizer of Health Care Strategies, Inc presented this proposal in October 2001.

Concern was raised as to whether such a program would offer an advantage over their existing bulk purchasing arrangements. Anthem observed, “As an eight-state health plan we already try to get leverage by scale. We did not opt to participate with New Hampshire, Vermont and Maine on a pharmacy program because of our concerns about the administration of the program.”

A Public Private Insurance Consortium. The question concerning putting all of the State’s health care business out to bid was cautiously considered by all of the insurers. They were concerned that it would reach beyond their established product lines in health insurance (e.g. Republic felt that companies tend to specialize and do not offer multiple product lines in any one state) as well as extend beyond what is typically considered health insurance (Worker’s Compensation). They were concerned about the higher risks in the non-group market, even if it was folded into a larger population. They also raised concern about adverse selection among small groups. They felt that there was no way to insure continued leverage with providers on rates and quality. And they felt that government had not been a good business partner in the past. All that said, the large group insurers were willing to review and consider this proposal if it were developed by the State.

New Products for Low Income Uninsured Individuals and Families. Republic indicated they are developing a PPO network product with high deductibles they hoped would be attractive to low-income individuals. All of the insurers indicated that they

would consider a primary care network product for low-income individuals. Harvard stated that it is in the process of developing a primary care network product in Massachusetts and would consider doing it New Hampshire.

Republic offered a list of issues that should be addressed.

- ? Products should be developed that require that all insurers work under the same conditions with same obligations. “All the carriers would have to work together. I’d object to anyone getting preferential treatment.”
- ? Competent market research is essential to target the products people will actually buy. Government should ask insurers to develop only those products that people want.
- ? The burden for the uninsured should be broadly allocated across the public and private sectors and should allow for private voluntary actions (from provider discounts to corporate cash assistance).
- ? Costs that are mandatory - like the high-risk pool assessments - should be spread across all markets. Equity across insurers is essential.

The insurers suggested other options for expanding coverage that include exploring the application of the Hawaii model that share risk between the employer and the insurer; designing a product based on the \$1,000 federal refund tax credit or creating premiums based the patients’ choice of their own referral network hospital and PCP.

Summary and Conclusions

The State of New Hampshire has recognized that a solution to the uninsured must involve private insurance carriers and health plans. Most people, including the uninsured, want private health insurance, a wide choice of providers and affordable premiums. However, many of the uninsured do not have health coverage because they cannot afford the premiums. This interview study was conducted in an environment of rising premiums that many worry threatens to increase the number of New Hampshire residents without health insurance.

In order to incorporate the perceptions and insights of insurers into the HRSA project, in February 2000 Bruce Spitz and Deborah Chollet conducted a series of comprehensive, structured interviews with representatives of the four major insurers in New Hampshire: American Republic Insurance Company (Republic), CIGNA HealthCare (Cigna), Anthem Blue Cross Blue Shield of New Hampshire Inc. (Anthem), and Harvard Pilgrim Health Care (Harvard). The interviews occurred in February 2002.

All the insurers interviewed registered similar concerns about the rising cost of health insurance premiums, which they said are determined primarily by the increasing prices being charged for the services they must reimburse. They said they feel they have relatively limited ability to negotiate more significant provider discounts or restrict patient access to services. Therefore, the insurers said that reductions in premiums could only be achieved by increasing the patients' financial obligations increased deductibles,

coinsurance and co-pays. The large group insurers believe that adding more insurance carriers will not address these underlying realities and might actually aggravate it by producing a market with more carriers who each have relatively less buying clout.

In terms of benefits paid, individual, non-group insurance is more costly than group coverage market. This is due to non-group insurance's relatively higher administrative costs and the prevalence of indemnity coverage without negotiated provider discounts. The insurers also argued that guaranteed issue and adverse selection made the non-group market a relatively high-risk population in which many individuals buy insurance when they were sick and drop it when they are healthy.

The insurers also commented on the widespread resistance among consumers, employers and the media to limiting access to services and providers, restricting physician referral, or in other ways significantly limiting utilization of medical services. The insurers anticipated further growth of enrollees' financial exposure for health care, as insurers raised cost sharing and narrowed the scope of covered benefits and employers required higher employee contributions to premiums in response to ongoing health care cost inflation. They suggested that making enrollees and employees more aware of health care costs via patient education and explanation of benefits might be helpful but acknowledged that this has been tried in the past with limited success. They offered no new or alternative strategies.

The insurers registered concern about state regulations, such as guaranteed issue, data reporting, taxes, and mandated benefits, but gave no hard numbers for the impact of specific regulations on premiums costs. They want to maintain a viable competitive marketplace for health care insurance and in that environment are willing to engage with regulators, elected officials and other carriers to developing solutions to the problem of rising premiums and the uninsured. Several insurers urged the consideration of regional solutions involving New Hampshire, Vermont and Maine.

Appendix A.

INSURANCE QUESTIONNAIRE

The Structure and Cost of the Health Care Market and Insurance

We are investigating the relationships between hospitals and physicians and the impact that those relationships have on competitive markets.

1. What is your estimate of the percentage of your participating primary care physicians (GP, FP, IM, Peds, etc) that are controlled by:
 - a. PHOs
 - b. Hospital employment
 - c. Other hospital arrangements (please specify)
2. What is your estimate of the percentage of participating physician specialists that are controlled by:
 - a. PHOs
 - b. Hospital employment
 - c. Other hospital arrangements (please specify)
3. How prevalent is the practice of multi-specialty group practices that do not allow health plan enrollees to select physicians outside of their group even though those outside physicians are within your provider network?
4. Are there any regions in the State where you find it difficult to sign physicians to your network? Do you have any idea what the reasons are for that difficulty?

States have been reconsidering the nature and extent of competition within their health insurance markets as well as the impact that competition has on those markets.

5. What is the minimum number of health plans that NH needs in order to have a competitive health insurance market?
6. How does the cost of health care in New Hampshire compare with other states?
7. Could you rank health care costs by geographic region? Or, what 3 geographic regions in the State have experienced the largest rate increases? What 3 have received the lowest?
8. How many hospital contracts have you renewed or re-negotiated in the past 2 years?
9. Have you increased the rates that you pay to hospitals for services?
 - a. If yes, what is the range of the percentage increases? What are the 3 most expensive regions in the State?
 - b. If no, have you decreased the rates you pay to hospitals? What is the range? What are the least expensive regions in the State?

10. How do the premiums you offer in New Hampshire compare with the premiums you offer in other states (higher, lower or the same)? What are the key reasons for the differences?
11. What is the dollar or percentage breakdown of your premium costs by:
 - a. Inpatient services
 - b. Outpatient services
 - c. Physician services
 - d. Pharmacy and supplies
 - e. Other medical services
 - f. Marketing your products
 - g. Fees paid to brokers
 - h. Claims administration (claims payment and oversight/auditing)
 - i. Profits
 - j. Other administrative costs
 - k. Taxes
12. Do you track the impact that new technology (new pharmaceuticals, new diagnostic equipment, etc.) is having on your costs? If so, how do you define new technology? What impact has new technology had on your costs between 1999 and 2000? Between 1995-2000?
13. What factors would help you develop a health insurance product with lower premiums?
14. A number of state regulations have an impact on your premiums or costs.
 - a. Which ones would you change?
 - b. Why?
 - c. How would you change them?
15. Many think that if employers made their employees more aware of the cost of health care, that their employees would be more conscientious in their consumption of health care services. What effect do you think the following would have on employee behavior:
 - a. Indicating the employer and employee's premium contribution on the employees' paycheck? What percentage of your clients currently does this?
 - b. Employee seminars on health care costs? What percentage of your clients currently does this?
 - c. Explanation of Benefits? What percentage of your clients currently does this?
 - d. Other employer actions you would recommend? What percentage of your clients currently does this?

The Decision To Purchase Insurance

16. What percentage of individuals disenroll each year?
 - a. Has that rate changed compared to the previous five years?

- b. Why are consumers disenrolling from coverage?
 - c. Have you analyzed the relationship between changes in the premium rate and disenrollment?
 - d. If so, what is that relationship?
17. What are the benefit buy-down trends?
- a. What percentage of your clients opted to buy down last year?
 - b. Has this trend changed over time?
 - c. What percentage of your buy-downs involve
 - i. Increased co-pays?
 - ii. Increased coinsurance?
 - iii. Increased deductibles?
 - iv. Reduced benefit coverage?
 - v. More restrictive utilization controls?
 - vi. Other (Please specify)?

New Products for the General Public

18. A Low Cost Option. If you were not constrained by any State laws or regulations what is the least costly health insurance product that you think would be attractive to the public at large? What benefits would that product offer? What financial requirements would it place on the consumer?
19. Public/Private Pooling of Risk and Purchase of Services. While the State is a major purchaser of health care, its ability to negotiate discounts with providers would be enhanced if it could expand the number of covered lives involved. As a major carrier in this State would you be willing to work with the State to jointly negotiate and purchase:
- a. Pharmaceuticals?
 - b. Eyeglasses?
 - c. Medical devices?
 - d. Other goods and services?
20. Under what conditions would you open enrollment for the public at large into a large group policy at the large group rate?

New Products for Low Income Uninsured Individuals and Families

A 1999 New Hampshire Survey estimated the number of uninsured residents at 96,000. Most of these individuals are in families with at least one full time worker who either cannot afford or is not offered coverage.

21. Do you have any plans for developing a product for low-income adults?
22. Would you consider offering a primary care product for low-income individuals?
23. If not, why not?

24. Do you have any recommendations for increasing insurance for the uninsured?

Appendix B.

Interviewers Background

Bruce Spitz is a health economist and President of the Spitz Consulting Group. For more than thirty years, he has examined alternative approaches for organizing, financing and reforming health care services. The Spitz Consulting Group has a multiyear contract to assist the State of New Hampshire redesign the way it: monitors and manages the health care system for all the residents in the State; works with its communities on health care issues; and provides information on market performance. Mr. Spitz has worked with the federal government, more than 20 states and a half dozen major cities (e.g., New York City, Boston, Cleveland and Denver). He has assisted several of the largest Foundations in the country (e.g., The W.K.Kellogg Foundation, Robert Wood Johnson Foundation, The Pew Memorial Trust) and participated in a number of international programs. Prior to founding the Spitz Consulting Group, he was a Management Professor at Brandeis University's Institute for Health Policy for 13 years.

Deborah Chollet is a Senior Fellow at Mathematica Policy Research, Inc. in Washington, D.C. She is responsible for leading research projects related to health insurance coverage, markets, and financing. She was previously a vice president at Alpha Center in Washington, D.C. Ms. Chollet has managed and conducted research on health insurance coverage and markets, the conversion of nonprofit hospitals to for-profit status, and Medicare supplemental insurance regulation, as well as provided technical assistance to state governments on related issues. She is a well-known and widely published researcher in her field.