LEGISLATIVE COMMITTEE MINUTES

SB541

Bill as Introduced

SB 541 - AS INTRODUCED

2016 SESSION

16-2984
01/09

SENATE BILL ***541***

AN ACT establishing a commission to study provider rates.

SPONSORS: Sen. Prescott, Dist 23; Sen. Avard, Dist 12; Sen. Boutin, Dist 16; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Daniels, Dist 11; Sen. Feltes, Dist 15; Sen. Forrester, Dist 2; Sen. Fuller Clark, Dist 21; Sen. Lasky, Dist 13; Sen. Reagan, Dist 17; Sen. Sanborn, Dist 9; Sen. Soucy, Dist 18; Sen. Stiles, Dist 24; Rep. Itse, Rock. 10; Rep. Almy, Graf. 13

COMMITTEE: Health and Human Services

ANALYSIS

This bill establishes a commission to study provider rates.

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 541 - AS INTRODUCED

16-2984
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Sixteen

AN ACT establishing a commission to study provider rates.

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

1 New Subdivision; Commission to Study Provider Rates. Amend RSA 400-A by inserting after section 67 the following new subdivision:

Commission to Study Provider Rates

400-A:68 Commission to Study Provider Rates.

I. There is established a commission to study provider rates.

II. The members of the commission shall be as follows:

(a) Two members of the senate, appointed by the president of the senate.

(b) Three members of the house of representatives, appointed by the speaker of the house of representatives.

(c) The commissioner of the department of health and human services, or designee.

(d) The insurance commissioner, or designee.

(e) A representative of the New Hampshire Hospital Association, appointed by the association.

(f) A representative of the New Hampshire Medical Society, appointed by the society.

(g) One member representing the private health insurance industry, appointed by the governor.

(h) A public member, appointed by the governor.

III. Members of the commission shall serve without compensation, except that legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

IV. The commission shall study provider rates. The commission's study shall include, but not be limited to, a determination of whether the public interest is violated when nonprofit hospitals offer the same services at different costs to different patients based on which insurance company is acting as third party payer.

V. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Six members of the commission shall constitute a quorum.

VI. The commission shall report its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2016.

2 Effective Date. This act shall take effect upon its passage.

SB 541 - AS AMENDED BY THE SENATE

03/24/2016 1068s

2016 SESSION

16-2984
01/09

SENATE BILL ***541***

AN ACT establishing a commission to study provider rates.

SPONSORS: Sen. Prescott, Dist 23; Sen. Avard, Dist 12; Sen. Boutin, Dist 16; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Daniels, Dist 11; Sen. Feltes, Dist 15; Sen. Forrester, Dist 2; Sen. Fuller Clark, Dist 21; Sen. Lasky, Dist 13; Sen. Reagan, Dist 17; Sen. Sanborn, Dist 9; Sen. Soucy, Dist 18; Sen. Stiles, Dist 24; Rep. Itse, Rock. 10; Rep. Almy, Graf. 13

COMMITTEE: Health and Human Services

ANALYSIS

This bill establishes a commission to study provider rates.

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

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Sixteen

AN ACT establishing a commission to study provider rates.

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

1 New Subdivision; Commission to Study Provider Rates. Amend RSA 400-A by inserting after section 67 the following new subdivision:

Commission to Study Provider Rates

400-A:68 Commission to Study Provider Rates.

I. There is established a commission to study provider rates.

II. The members of the commission shall be as follows:

(a) Two members of the senate, appointed by the president of the senate.

(b) Three members of the house of representatives, appointed by the speaker of the house of representatives.

(c) The commissioner of the department of health and human services, or designee.

(d) The insurance commissioner, or designee.

(e) A representative of the New Hampshire Hospital Association, appointed by the association.

(f) A representative of the New Hampshire Medical Society, appointed by the society.

(g) One member representing the private health insurance industry, appointed by the New Hampshire chapter of America's Health Insurance Plans.

(h) A public member, appointed by the governor.

III. Members of the commission shall serve without compensation, except that legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

IV. The commission shall study provider rates. The commission's study shall include, but not be limited to, a determination of whether the public interest is violated when nonprofit hospitals offer the same services at different costs to different patients based on which insurance company is acting as third party payer.

V. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Six members of the commission shall constitute a quorum.

VI. The commission shall report its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2016.

2 Effective Date. This act shall take effect upon its passage.

Amendments

Sen. Prescott, Dist 23
March 1, 2016
2016-0796s
09/04

Amendment to SB 541

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

AN ACT establishing a commission to study provider payment rates.

Amend the bill by replacing section 1 with the following:

1 New Subdivision; Commission to Study Provider Payment Rates. Amend RSA 400-A by inserting after section 67 the following new subdivision:

Commission to Study Provider Payment Rates

400-A:68 Commission to Study Provider Payment Rates.

I. There is established a commission to study provider payment rates.

II. The members of the commission shall be as follows:

(a) Two members of the senate, appointed by the president of the senate.

(b) Three members of the house of representatives, appointed by the speaker of the house of representatives.

(c) The commissioner of the department of health and human services, or designee.

(d) The insurance commissioner, or designee.

(e) A representative of the New Hampshire Hospital Association, appointed by the association.

(f) A representative of the New Hampshire Medical Society, appointed by the society.

(g) One member representing the private health insurance industry, appointed by the governor.

(h) A public member, appointed by the governor.

III. Members of the commission shall serve without compensation, except that legislative members of the commission shall receive mileage at the legislative rate when attending to the duties of the commission.

IV. The commission shall study provider payment rates. The commission's study shall include, but not be limited to, a determination of whether the public benefits when nonprofit hospitals offer the same services to different patients but agree to negotiated contract rates that include lower reimbursement for some patients compared to others, based on which insurance company the patient is covered by, whether the carrier is acting as a third party payer for a self-funded employer, or whether the patient is paying cash and considered uninsured or a self-pay

patient.

V. The members of the commission shall elect a chairperson from among the members. The first meeting of the commission shall be called by the first-named senate member. The first meeting of the commission shall be held within 45 days of the effective date of this section. Six members of the commission shall constitute a quorum.

VI. The commission shall report its findings and any recommendations for proposed legislation to the president of the senate, the speaker of the house of representatives, the senate clerk, the house clerk, the governor, and the state library on or before November 1, 2016.

2016-0796s

AMENDED ANALYSIS

This bill establishes a commission to study provider payment rates.

Sen. Sanborn, Dist 9
March 14, 2016
2016-0995s
01/09

Amendment to SB 541

Amend RSA 400-A:68, II(g) as inserted by section 1 of the bill by replacing it with the following:

(g) One member representing the private health insurance industry, appointed by the New Hampshire chapter of America's Health Insurance Plans.

Health and Human Services
March 16, 2016
2016-1068s
01/09

Amendment to SB 541

Amend RSA 400-A:68, II(g) as inserted by section 1 of the bill by replacing it with the following:

(g) One member representing the private health insurance industry, appointed by the New Hampshire chapter of America's Health Insurance Plans.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Andy Sanborn, Chair
Sen Molly Kelly, Vice Chair
Sen Kevin Avard, Member
Sen Sharon Carson, Member
Sen Martha Fuller Clark, Member

Date: February 17, 2016

HEARINGS

Tuesday	03/01/2016
(Day)	(Date)

Health and Human Services	LOB 101	1:00 p.m.
(Name of Committee)	(Place)	(Time)

EXECUTIVE SESSION MAY FOLLOW

1:00 p.m.	**SB 541**	establishing a commission to study provider rates.
1:20 p.m.	**SB 537**	relative to record management of abuse and neglect reports.
1:40 p.m.	**SB 538**	relative to children taken into custody under the child protection act and relative to the commission to review child abuse fatalities.
2:10 p.m.	**SB 539**	relative to access to records under the child protection act.

Sponsors:

SB 541

Sen. Prescott	Sen. Avard	Sen. Boutin	Sen. Bradley
Sen. D'Allesandro	Sen. Daniels	Sen. Feltes	Sen. Forrester
Sen. Fuller Clark	Sen. Lasky	Sen. Reagan	Sen. Sanborn
Sen. Soucy	Sen. Stiles	Rep. Itse	Rep. Almy

SB 537

Sen. Boutin	Sen. Fuller Clark	Sen. Soucy	Sen. Kelly
Sen. Woodburn	Sen. Reagan	Sen. Stiles	Sen. Watters
Sen. Lasky	Sen. Morse	Sen. Bradley	Rep. Weber
Rep. Berrien	Rep. P. Long		

SB 538

Sen. Boutin	Sen. Fuller Clark	Sen. Soucy	Sen. Kelly
Sen. Woodburn	Sen. Reagan	Sen. Stiles	Sen. Watters
Sen. Bradley	Sen. Lasky	Rep. Weber	Rep. Berrien

SB 539

Sen. Boutin	Sen. Fuller Clark	Sen. Soucy	Sen. Kelly
Sen. Woodburn	Sen. Reagan	Sen. Stiles	Sen. Watters
Sen. Bradley	Sen. Lasky	Rep. Weber	Rep. Berrien

Kelly Flathers 271-3091

Andy Sanborn
Chairman

Senate Health and Human Services Committee

Kelly Flathers 271-3091

SB 541, establishing a commission to study provider rates.

Hearing Date: March 1, 2016

Time Opened: 1:03 p.m. **Time Closed:** 1:53 p.m.

Members of the Committee Present: Senators Sanborn, Kelly, Avard and Fuller Clark

Members of the Committee Absent: Senator Carson

Bill Analysis: This bill establishes a commission to study provider rates.

Sponsors:

Sen. Prescott	Sen. Avard	Sen. Boutin
Sen. Bradley	Sen. D'Allesandro	Sen. Daniels
Sen. Feltes	Sen. Forrester	Sen. Fuller Clark
Sen. Lasky	Sen. Reagan	Sen. Sanborn
Sen. Soucy	Sen. Stiles	Rep. Itse
Rep. Almy		

Who supports the bill: Sen. Lasky - District 13; Sen. Forrester - District 2; Sen. Boutin - District 16; Sen. Daniels - District 11; Sen. Feltes - District 15; Sen. Avard - District 12; Rep. LeBrun - Hillsborough 32

Who opposes the bill: Heidi Kroll - AHIP

Who is neutral on the bill: Tyler Brannen - NH Insurance Department; Paula Minnehan - NH Hospital Association; Paula Rogers - Anthem

Summary of testimony presented in support:
Senator Prescott - District 23 (Prime): I have an amendment for this bill that refines language on line 28 of the first page. This bill establishes a commission to study provider payment rates. MVP came to our state to offer health insurance and eventually left because they could not formulate a good provider network with reasonable payments. A study commission will have members trying to be inclusive of all parts of the story. I would agree to any changes to make the commission as inclusive as possible. The crux of the question is on line 28. It's a determination of whether the public benefits when nonprofit hospitals offer the same services to

different patients, but agree to negotiate a contract with rates that include lower reimbursements for some patients based on which insurance company the patient is covered by, whether the carrier is acting as a third party payer for a self-funded employer or whether the patient is paying cash. We search for competitive health insurance rates and sometimes find that there is just one choice. To offset increased rates we increase deductibles and copays. My business's health insurance costs went up 38% in one year. We do not have enough competition in our state. We need a study commission to see if we need more transparency in provider payment rates.

Senator Sanborn: Have you heard of any other states where non-profit hospitals or providers are bound to charge the same rate predicated on their non-profit status? Is there a difference in non-profits providing medical care versus for-profits?

Senator Prescott: There is a stark difference. If you want to become a non-profit, you have to prove you are providing a service of public good. My question is whether or not that is truly the case.

Senator Sanborn: Are you less concerned with rates charged by for-profit hospitals than non-profit?

Senator Prescott: Yes. For-profit hospitals do not receive preferential treatment with taxation. They pay taxes like any other corporation and there is no obligation other than their own mission statement. Non-profits don't have to pay business enterprise tax or real estate tax. Along with that comes the legal obligation to prove they are providing a public good. I do not want to restrict a hospital from negotiating rates. Our goal is that each hospital works to set their rates to make sure that they are living up to the law of being a nonprofit, as well as covering their costs. That would be, for the benefit of the public, equal across the board for any insurance provider. Through a study commission we could see if that meets the criteria for what a nonprofit should be doing. The checks and balances for this type of scenario, where the hospital sets their rates, would be from greater transparency. That would bring in greater public scrutiny to make sure there are no outliers.

Summary of testimony presented in opposition:
Heidi Kroll - AHIP: Contracts between carriers and hospitals are confidential; they are the result of private negotiations. That could present a problem for what the study commission wants to study. This bill is potentially heading down the path of rate setting, which could potentially lead to higher rates. Every carrier has an incentive to negotiate the best rates possible with the provider. If the incentive is removed by making that rate available to every other carrier, it's not clear that any carriers are going to have a strong motivation to negotiate it down. Part of the negotiations involve offering some level of confidence to the provider that they are going to provide a certain volume of business in exchange for a greater discount. From a hospital's perspective, if they think a certain rate has to be given to every carrier, volume may no longer be a factor. They'll have to assume the volume is low and won't give a big discount. From the NH AHIP perspective, competitive markets are a good thing. Carriers have every incentive to negotiate the best deal they can. Under this bill, if it is heading in the

direction of rate setting, there's a question on what that means for competitive markets.

Senator Sanborn: Are we talking about what rate an insurance carrier can demand or what rate a non-profit hospital can charge? We have some of the highest costs for health care in America and we are also one of the healthiest states in America. What is the marketplace doing to make health care more affordable?

Heidi Kroll: The 85/15 gets reflected in premiums and that's what carriers compete on, so there is an incentive to keep premiums low. It's not unique to NH that we have higher deductibles and copays. Carriers are doing everything that they can, such as having value added networks, quality providers, and negotiating the best rates they can. There's a lot of effort to move away from fee-for-service and toward evidence-based results and rewarding outcomes.

Senator Kelly: Do you feel that the commission's makeup adequately represents your voice so that your concerns would be heard?

Heidi Kroll: Yes, on line 21 there is one member representing the private health insurance industry appointed by the Governor. Things may be slowed down by putting that responsibility on the Governor's office. Instead, that member could be appointed by AHIP to expedite the process.

Neutral Information Presented:
Tyler Brannen - NH Insurance Department: The Insurance Department has done a lot looking at health care costs over the years. The health cost website is one example of that. You can identify you insurer and see how much variability there is for the same service among different health care providers. The department has also done a couple of reports looking at the average discount insurance companies get with health care providers. The second of those reports is in your materials. The graph you're looking at summarizes what's in the report. The larger the insurer, the better discount they get on average for health care providers across the state. On the graph there is the percentage of the charges in one column, which is a proxy for market share, and the average discount for all providers in the other column. Smaller insurance companies are not able to get the same discounts as Anthem, Cigna, or Harvard Pilgrim. It depends, to an extent, on the type of product they have. The bill is focused on the differences that each insurer pays the same provider for the same service, rather than the differences that the insurer pays different providers for the same service. One of the biggest challenges for an insurance company coming into NH is developing a provider network at competitive rates with the market leader in that state. They don't necessarily have the leverage. The commission is focused on studying that difference and whether it is a benefit to NH residents. That's different than looking at the variability among different health care providers and the payment rates associated with those services. NH does have a prohibition on "most favored nation" language or "equally favored nation" language. An insurance company can't go into a negotiation with a hospital and say "I don't care what deal you give me, but it has to be better than any of my competitors." It is likewise prohibited for them to ask for the same deal

they're giving to competitors. The commission would have to look at the statutes to make any changes. We are moving away, slowly, from a purely fee-for-service way of paying for health care services. We are thinking more about risk contracts and value based incentives. To make a comparison among different reimbursement contract arrangements, you have to consider the fact that they are not all using the same methodology. The challenge that Sen. Prescott is trying to address, the payment differential insurance companies face with the same provider and the same service, is worth looking into.

Paula Minnehan - NH Hospital Association: We share the same concerns as AHIP. Hospitals provided $400 million in community benefits last year. Through the charitable trusts statute, they provide a lot of charity care and provide free or reduced services. They report that every year through community benefits and it is important to acknowledge. Regarding contracts with larger providers, there are administrative efficiencies that result from their size. One challenge for NH is our unique geography; we are a small state. We can try to have more carriers come in but we are limited in how many insured lives we have. A good example is Medicaid Managed Care. We originally had 3 carriers but 1 couldn't survive without the economies of scale. We were disappointed when MVP left as well. We aren't opposed to a study committee but I don't know how much can be discussed. It's leaning toward most favored nation, which is outlawed here and in many other states. We are worried about rate setting as well. Our hospitals, both for-profit and nonprofit, provide a lot of charity care and community benefits.

Senator Sanborn: When you suggest that, in the aggregate, our 26 hospitals provide $400 million in care, is that in addition to uncompensated care?

Paula Minnehan: The report breaks it all down. Community benefits are a different category through the Charitable Trusts Division at the Attorney General's office.

Senator Sanborn: In the aggregate, our 26 hospitals had $5.5 billion in total revenue two years ago. If we are allowing another $400 million in community benefits, shouldn't we stop that and cut rates across the board?

Paula Minnehan: They're in-kind services. There are certain requirements to be a charitable trust. A lot of them have physician offices and do pay property tax. They help their communities maintain surrounding infrastructure. Uncompensated care and how they're reimbursed is different from community benefits.

Senator Fuller Clark: Why are our rates so high? Is it because of our relatively small population? Does our small minority population help balance that out?

Paula Minnehan: The quality of health care in NH is superb. States like texas are much larger and scale matters a lot. Our population is aging and we utilize more services than other states.

Senator Fuller Clark: If you were to eliminate the disparity between what hospitals charge in the nonprofit sector, wouldn't that reduce the ability for a hospital to be competitive?

Paula Minnehan: Yes. To clarify, hospitals set their charges from what the board agrees to. These are based on a number of factors, including the cost shifts from Medicaid and Medicare. In our state we are paid 85% of the costs for Medicare. We are the lowest state in the country for Medicaid. Those cost shifts are being mitigated by uncompensated care reimbursement through DSH, which is helping, but not taking care of the entire issue. Most of our hospitals have 50-60% of their patients on Medicare. Hospitals in the north country may have 15% on Medicaid. Charges are set by the board. Costs are dictated by what the cost report shows. All of the allowable costs get factored in, which varies by hospital. Reimbursement varies by carrier within each hospital. The issue is in the reimbursement side of things, not the charges.

Senator Avard: Could you elaborate on high deductibles that go to bad debt? Does it end up hurting both the consumer and the provider?

Paula Minnehan: Yes. It ends up being a cost of doing business. People often get on a payment plan, pay off as much as they can, and then it goes into bad debt.

Senator Avard: How did deductibles become so high?

Paula Minnehan: That's why we have this debate about transparency. When people pay a lot out of pocket and that's all they use for the entire year, it feels like they don't have insurance at all.

Senator Sanborn: Before a patient hits their deductible, are hospitals charging the negotiated contract rate or a different rate?

Paula Minnehan: It goes to the carrier first and gets the appropriate discount, and then goes to you. The negotiated rate is applied to the deductible.

Senator Avard: Are there any figures on what percentage of the population goes into bad debt? Do taxpayers end up footing the bill?

Paula Minnehan: It goes into the cost structure. It's a cost to the hospital and they adjust for it. Medicare allows a little bit of bad debt adjustment for the Medicare population. They do not factor bad debt into Medicaid uncompensated care. I'll get the data for you.

Senator Avard: Our population is aging rapidly. Is this going to be a big problem in the future?

Paula Minnehan: Yes, especially on the Medicare side.

Paula Rogers - Anthem: I don't want to oppose the study of anything, but I advise that you understand exactly what you're looking for and for what purpose. Senator Prescott's stated purpose is that individual hospitals, consistent with the laws of the state and their own cost structure, would set reimbursement rates. These rates could vary, but whatever carrier came with a member seeking services in that setting would charged the same. This is a unique proposal. My concern would be to understand fully what the purpose of the commission is. NH has high costs but I would argue most of it is the cost of care. There are high co-pays but if they weren't high, the premiums would become unaffordable. Premiums are largely built on the cost of care. We are looking at new cost structures that would reward the best care at the best time and best place. There is a lot of unnecessary care happening as well. Change requires public will, not just data. Make sure you know what you're looking for and that it fits into what's possible in the state.

Senator Avard: What is an example of unnecessary care?

Paula Rogers: An example is 3D mammograms. For certain conditions it is necessary, but for most women it is not. Hospitals also needlessly waste hundreds of thousands of dollars of medicine.

Future Action: Pending

KEF
Date Hearing Report completed: March 4, 2016

Speakers

Senate Health and Human Services Committee: Sign-In Sheet

Date: 3/1/2016 Time: 1:00 PM Public Hearing on SB 541

SB 541 establishing a commission to study provider rates.

Name	Representing	Support	Oppose	Speaking?	Yes	No
Sen. Bette Lasky	SD #13	☑	☐		☐	☑
Sen. Jeanie Forrester	District #2	☑	☐		☐	☑
Senator Bowden	SD #16	☒	☐		☐	☒
Senator Daniels	SD #11	☑	☐		☐	☒
Sen. Feltes	SD #15	☑	☐		☐	☑
Sen. Avard	SD #12	☒	☐		☐	☒
Tyler Bannen	NH Insurance Dept	☐	☐		☒	☐
Heidi Kroll	AHIP	☐	☒		☒	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐
		☐	☐		☐	☐

Senate Health and Human Services Committee: Sign-In Sheet

Date: 3/1/2016 Time: 1:00 PM Public Hearing on SB 541

SB 541 establishing a commission to study provider rates.

Name	Representing	Support	Oppose	Speaking? Yes	Speaking? No
Rep. Don LeBrun	Hills 32	☒	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Senate Health and Human Services Committee: Sign-In Sheet

Date: 3/1/2016 Time: 1:00 PM Public Hearing on SB 541

SB 541 establishing a commission to study provider rates.

Name	Representing	Support / Oppose	Speaking?
Paula Minnehan	NH Hospital Assoc	Support ☐ Oppose ☐	Yes ☒ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐

Testimony

Tyler Brannen SB541

Payments to providers part II: another look at carrier discounts

Parousia

New Hampshire Insurance Department

August 30, 2012

Introduction & Background

In early 2010, the New Hampshire Insurance Department (NHID) performed an analysis of the health care provider discounts from charges obtained by health insurance companies, in order to assess the competitiveness of carriers operating in the state. This analysis is an update of that study. The original study can be found here: (http://www.nh.gov/insurance/reports/documents/pay_prov.pdf). Since this is an update to a prior study, the methodology and discussion sections are moved later in the report, beginning on page 11.

The NHID concluded that based on 2009 data, New Hampshire insurance market had a limited amount of competition and Anthem maintained discounts that were either equal to or better than the market segment leader. Carriers discounts were compared within plan types (or product lines), such as HMO, PPO, POS, and indemnity.

Summary Findings

Only three carriers, Anthem-New Hampshire, Harvard Pilgrim Health Care (HPHC), and Cigna/Connecticut General Life Insurance (Cigna/CGLI), have both substantial market share and competitive provider discounts. All remaining carriers will struggle to become significant players in the market unless they can substantially change their provider contracts or find a way to overcome what is often a ten to thirty percent disadvantage in their payment levels for health care services.

Anthem continues to hold the greatest market share and frequently some of the most favorable discounts across health insurance plan types, but the competitive advantage is not as pronounced as it was in the 2010 study. HMO and POS products are still very popular in New Hampshire, and Anthem is at or near the top in these markets. PPO products continue to be popular across New Hampshire, although less so than nationally. For PPO products, Anthem does not have the most favorable contracts, as both Cigna/CGLI and HPHC show deeper average discounts. Very few members are still enrolled in traditional indemnity health insurance products, but Anthem continues to have the most substantial discounts, although to a lesser degree than previously observed.

Company	Carrier Portion of HMO Charges	HMO Discount	Carrier Portion of POS Charges	POS Discount	Carrier Portion of PPO Charges	PPO Discount	Carrier Portion of Indemnity Charges	Indemnity Discount
Aetna	0%	25%	35%	25%	1%	24%	4%	17%
All Other Ins	NA		NA		1%	22%	27%	24%
Anthem - NH	67%	41%	55%	**41%**	27%	34%	69%	**26%**
CIGNA/CGLI			4%	27%	37%	**37%**		
Harvard Pilgrim	31%	**42%**	4%	**41%**	23%	36%		
MVP	NA				6%	30%	NA	
NH Health Plan			NA		3%	24%		
Tufts	2%	31%			NA			
United Healthcare			3%	27%	0%	39%		
Average Discount		41%		35%		35%		25%

On the chart, the distribution of charges is shown as a proxy for market share. In most cases, bolded figures show the largest discounts from provider charges.[1]

Anthem-NH

Anthem has the largest market share overall and frequently has the most favorable average discounts. Anthem is within one percentage point of HPHC for HMO services, tied with HPHC for POS services, and has the greatest discount for indemnity products. Anthem's discount trails Cigna/CGLI for PPO services by three percentage points, or about eight percent. This means Anthem will need to pay on average almost five percent more than Cigna/CGLI for health care services provided to PPO members.

HPHC

HPHC has a small advantage over Anthem for HMO plans and is even with Anthem for POS discounts. HPHC will pay about two percent more than Cigna for PPO services, but about three percent less than Anthem.

Cigna/CGLI

Cigna/CGLI has the most favorable discount for PPO products, but is not competitive with Anthem or HPHC for the POS products. With a 27 percent average discount as compared with 41 percent for Anthem/HPHC, Cigna/CGLI will need to pay on average 24 percent more for POS services than Anthem or HPHC.

MVP

While maintaining a relatively small portion of the market for PPO products, MVP will pay six percent more than Anthem and eleven percent more than Cigna for these health care services.

[1] One exception is United Healthcare and the PPO discount. Since United has less than 0.5% of the total PPO provider charges, the discount rate may not be comparable to that shown for other carriers.

Aetna
Aetna has similar provider reimbursement rates regardless of the product line (HMO, POS, PPO, or indemnity products). Despite substantial medical claims in the POS market, Aetna does not have contracts that are competitive with HPHC or Anthem.

United Healthcare
United Healthcare appears to have the deepest discounts of all the major carriers in the PPO market. This may be due to favorable contracts with just a few select providers and an uneven distribution of members across the state. United Healthcare incurred almost $3 million in charges for PPO, but this may not be enough to accurately compare the discount to other carriers. If the rate represents what United has been able to obtain from providers across the state, then United should be well positioned to expand their membership base. United's average discount is not competitive with Anthem or HPHC for POS products, and is similar to that of Cigna/CGLI and Aetna.

Comparisons to the 2010 NHID Study

The HPHC and Anthem discounts are very similar for HMO products. The earlier analysis showed that with a ten percent difference in the POS discount rate, HPHC was not competitive with Anthem. In the current analysis, HPHC has matched Anthem's POS discount rate. Likewise, HPHC has reversed a competitive disadvantage with Anthem in the PPO market and now has a moderate advantage.

Cigna was formerly tied with Anthem as the class leader for PPO products, and has since improved upon its position relative to Anthem.

MVP's standing relative to the major competitors in the PPO market is now weaker.

In the prior study, Aetna was included under the "all other" insurance category. Now shown separately, both Aetna and the "all other" insurance company category offer discounts for indemnity products that are closer to the Anthem discount, with the "all other" insurance discount fairly close to Anthem's rate.

In Depth Findings

Comparing Aggregate Charges and Payments

Using the New Hampshire Comprehensive Health Care Information System (NHCHIS), the NHID compared provider discounts for all medical care services (exclusive of prescription drug benefit costs) and determined the overall aggregate discount by carrier during the calendar year of 2011.

These discount rates are calculated by summing total charges and total payments (including member liability) and reflect the overall weighted average. Calculating discounts this way best represents the net financial impact to carriers. The rates may be influenced by relatively few contracts with large provider organizations, or contracts with deep discounts for very expensive services. For these reasons, the methodology does not necessarily reflect the most common contract rates. The data are stratified by product line, as reimbursement rates often vary by product line.

There are substantial differences in reimbursement rates by provider type, specifically between hospital and non-hospital providers.

Hospital only average discounts:

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	10%	13%	10%	19%
All Other Insurance	NA	NA	16%	16%
Anthem - NH	39%	39%	28%	14%
CIGNA	NA	16%	34%	NA
Harvard Pilgrim HC	41%	38%	33%	
MVP	NA	NA	24%	
NH Health Plan			23%	
Tufts Insurance Co	26%		NA	
United Healthcare	NA	20%	25%	
Average Discount	40%	29%	31%	14%

Non-hospital provider discounts:

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	44%	40%	37%	14%
All Other Insurance	NA	NA	32%	36%
Anthem - NH	43%	44%	42%	41%
CIGNA	NA	42%	42%	NA
Harvard Pilgrim	43%	46%	39%	
MVP	NA	NA	38%	
NH Health Plan			29%	
Tufts Insurance Co	36%		NA	
United Healthcare	NA	38%	46%	
Average Discount	43%	42%	41%	39%

Key Observations:

- Carriers tend to obtain deeper discounts from non-hospital providers than from hospitals.
- The smallest carriers are least competitive with the major carriers with discounts for hospital services, but in many cases have obtained competitive rates with non-hospital providers.
- The range between the average discounts by carrier and product type is widest for hospital payments, and comparatively narrow among non-hospital providers.

Separating non-hospital provider specialties shows inconsistencies among carriers that are not evident when provider specialties are combined. Below are the top professional specialties (based on total spend) and the corresponding discounts:

Family/General Practice

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	30%	27%	30%	18%
All Other Insurance	NA	NA	28%	29%
Anthem - NH	27%	26%	26%	32%
CIGNA	NA	33%	31%	NA
Harvard Pilgrim	26%	26%	23%	
MVP	NA	NA	23%	
NH Health Plan			29%	
Tufts Insurance Co	19%		NA	
United Healthcare	NA	26%	25%	
Average Discount	26%	27%	27%	30%

General Internal Medicine

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	41%	34%	34%	3%
All Other Insurance	NA	NA	30%	29%
Anthem - NH	37%	36%	37%	38%
CIGNA	NA	42%	39%	NA
Harvard Pilgrim	37%	33%	33%	
MVP	NA	NA	35%	
NH Health Plan			26%	
Tufts Insurance Co	30%		NA	
United Healthcare	NA	32%	31%	
Average Discount	37%	35%	36%	35%

Orthopedic Surgery

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	69%	62%	54%	18%
All Other Insurance	NA	NA	49%	53%
Anthem - NH	62%	63%	61%	60%
CIGNA	NA	60%	61%	NA
Harvard Pilgrim HC	64%	68%	61%	
MVP	NA	NA	55%	
NH Health Plan			38%	
Tufts Insurance Co	59%		NA	
United Healthcare	NA	58%	66%	
Average Discount	63%	63%	59%	58%

Radiology

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	45%	41%	39%	14%
All Other Insurance	NA	NA	22%	34%
Anthem - NH	49%	51%	53%	42%
CIGNA	NA	51%	50%	NA
Harvard Pilgrim HC	47%	46%	44%	
MVP	NA	NA	37%	
NH Health Plan			16%	
Tufts Insurance Co	46%		NA	
United Healthcare	NA	31%	26%	
Average Discount	48%	46%	47%	39%

Obstetric/Gynecology

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	40%	32%	28%	5%
All Other Insurance	NA	NA	33%	32%
Anthem - NH	37%	38%	39%	33%
CIGNA	NA	39%	37%	NA
Harvard Pilgrim	37%	37%	34%	
MVP	NA	NA	34%	
NH Health Plan			29%	
Tufts Insurance Co	35%		NA	
United Healthcare	NA	32%	35%	
Average Discount	37%	35%	36%	32%

Anesthesiology/Pain Management

Company	HMO Discount	POS Discount	PPO Discount	Indemnity Discount
Aetna	41%	40%	39%	4%
All Other Insurance	NA	NA	26%	37%
Anthem - NH	42%	44%	44%	43%
CIGNA	NA	35%	36%	NA
Harvard Pilgrim HC	45%	44%	43%	
MVP	NA	NA	32%	
NH Health Plan			20%	
Tufts Insurance Co	36%		NA	
United Healthcare	NA	38%	33%	
Average Discount	43%	42%	39%	40%

Key Observations:

- Average discount varies greatly among specialties. Among those shown above, discounts are smallest within the Family/General Practice specialty, and largest in the Orthopedic Surgery specialty.

Limitations of Aggregation

The discounts reported above are important because they provide information about how contract rates influence overall payments to providers. However, aggregating data to calculate an overall discount does not adequately reveal how individual contract rates differ. A small number of contracts - with the hospitals that receive most of the health care dollars - will greatly influence the overall discounts reported above.

Simple Averaging and Statistical Differences

The next section uses the calculated discount rate for provider charges and payments for a particular day, and tracks them as a single observation. This reduces the impact of a relatively few expensive cases, but does not go down to the level of detail that exists on a per claim basis. This is because on a particular day, multiple claims may exist for lab and radiology services, and summarizing these claims will reduce the overly specific effect of multiple small claims in a day with different discounts. By tracking in this manner, we can measure what the average discount rate is, weighting encounters equally. This allows for a more precise measurement of the differences among carriers. Information is displayed separately for HMO, POS, PPO, and Indemnity. Averages are reported, as well as upper and lower confidence intervals (at the .05 level). If there is no overlap between the confidence interval (CI) of different carriers, there is a statistical difference between the two being compared. When there is not a statistical difference, variation between rates may be due to chance alone.

The discount results differ between methodologies, highlighting the fact that the distribution of the most aggressive discounts is not consistent across provider types, or between carriers and product types.

HMO – All Providers Included

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	2,582	31.0%	30.2%	31.8%
Anthem - NH	1,151,625	33.1%	33.1%	33.1%
Harvard Pilgrim HC	592,126	32.0%	31.9%	32.0%
Tufts Insurance Co	34,968	26.7%	26.5%	26.9%

HMO – Hospitals Only

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	549	19.9%	18.8%	21.0%
Anthem - NH	222,249	38.1%	38.0%	38.2%
Harvard Pilgrim HC	111,163	39.5%	39.4%	39.6%
Tufts Insurance Co	6,053	29.7%	29.4%	30.1%

HMO – No Hospitals

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	2,033	34.0%	33.1%	35.0%
Anthem - NH	929,376	31.9%	31.9%	31.9%
Harvard Pilgrim HC	480,963	30.2%	30.2%	30.3%
Tufts Insurance Co	28,915	26.1%	25.9%	26.3%

POS – All Providers

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	250,464	29.6%	29.5%	29.7%
Anthem - NH	372,449	32.9%	32.9%	33.0%
CIGNA	27,159	33.5%	33.2%	33.7%
Harvard Pilgrim HC	27,614	31.3%	31.1%	31.6%
United Healthcare	19,245	27.5%	27.2%	27.8%

POS – Hospitals Only

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	46,356	22%	22%	22%
Anthem - NH	69,629	38%	38%	38%
CIGNA	7,150	36%	35%	36%
Harvard Pilgrim HC	5,137	33%	32%	33%
United Healthcare	4,209	20%	20%	21%

POS – No Hospitals

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	204,108	31.4%	31.3%	31.5%
Anthem - NH	302,820	31.7%	31.7%	31.8%
CIGNA	20,009	32.7%	32.4%	33.0%
Harvard Pilgrim HC	22,477	31.0%	30.7%	31.2%
United Healthcare	15,036	29.4%	29.1%	29.8%

PPO – All Providers

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	28,829	31.9%	31.6%	32.1%
All Other Insurance	20,608	24.7%	24.4%	24.9%
Anthem - NH	398,216	30.7%	30.6%	30.7%
CIGNA	558,207	33.6%	33.5%	33.6%
Harvard Pilgrim HC	328,844	29.9%	29.8%	30.0%
MVP	95,865	25.7%	25.6%	25.9%
NH Health Plan	19,028	24.4%	24.2%	24.6%
United Healthcare	6,266	32.1%	31.6%	32.5%

PPO – Hospitals Only

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	3,430	18.9%	18.4%	19.4%
All Other Insurance	4,571	14.8%	14.4%	15.1%
Anthem - NH	83,123	29.3%	29.2%	29.5%
CIGNA	151,615	35.5%	35.4%	35.6%
Harvard Pilgrim HC	64,868	31.1%	31.0%	31.2%
MVP	20,623	23.2%	23.0%	23.3%
NH Health Plan	4,686	21.1%	20.8%	21.3%
United Healthcare	460	22.2%	20.8%	23.6%

PPO – No Hospitals

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	25,399	33.6%	33.4%	33.9%
All Other Insurance	16,037	27.5%	27.2%	27.8%
Anthem - NH	315,093	31.0%	30.9%	31.1%
CIGNA	406,592	32.9%	32.8%	32.9%
Harvard Pilgrim HC	263,976	29.6%	29.6%	29.7%
MVP	75,242	26.4%	26.3%	26.6%
NH Health Plan	14,342	25.5%	25.2%	25.7%
United Healthcare	5,806	32.9%	32.4%	33.3%

Indemnity – All Providers

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	1,474	8.5%	7.6%	9.3%
All Other Insurance	13,186	26.9%	26.5%	27.2%
Anthem - NH	36,789	29.2%	29.0%	29.4%

Indemnity – Hospitals Only

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	248	13.3%	11.7%	14.9%
All Other Insurance	2,767	16.8%	16.3%	17.4%
Anthem - NH	6,716	15.3%	15.0%	15.5%

Indemnity – No Hospitals

Company	Observations	Average Discount	Lower CI	Upper CI
Aetna	1,226	7.5%	6.6%	8.4%
All Other Insurance	10,419	29.5%	29.1%	30.0%
Anthem - NH	30,073	32.3%	32.1%	32.5%

Discussion

One way insurance carriers compete with each other is through the reimbursement contracts they have with health care providers. All other things being equal, the less a carrier pays for health care, the more it can retain for administrative surplus or for reducing future premium increases.

Health insurance carriers use many tools to control health care costs, including utilization and disease management programs, benefit designs with targeted cost sharing, health cost transparency tools, and alternative reimbursement methodologies that are intended to

create provider incentives for more cost efficient care. Each of these mechanisms may reduce costs to some degree, but contract rates that determine provider payments are comparatively simple to measure.

For example, if two carriers have a similar book of business, the same premiums, and a ninety percent loss ratio, but one carrier obtains an average discount of 31 percent while its competitor obtains a 34 percent discount, the administrative cost portion of the premium would need to be forty percent less for the first carrier to break even.

The Insurance Department's mission is to promote and protect the public good by ensuring the existence of a competitive insurance market. Evidence of substantial differences among carrier contracts raises the question of whether the market is competitive.

Provider Discounts

For an insurance carrier, a provider discount is the difference between the charge rate for health care services and the contractually determined reimbursement rate. Because it determines the amount that will be paid for the service, the discount from charges is important to the health care provider, the carrier and the patient. The patient's cost sharing liability will be based on the discounted rate. Even when the terms of a reimbursement contract are not based on the charge rate, an equivalent discount from charges can be calculated for the purposes of comparison and analysis.

Contractually agreed-upon reimbursement rates are based on a number of factors, and a discussion of the broader issues related to contract rates is beyond the scope of this analysis. Historically, the lowest payment rates were associated with HMO products and the highest with indemnity products. This difference results from the theory that patients enrolled in the most restrictive plan design can be directed to specific providers based on the preference of the insurance carrier. To avoid losing patients to a competitor, health care providers agree to lower payment levels for HMO members. From a practical standpoint, provider networks in New Hampshire are similar across carriers, and there is limited evidence that carriers have been highly successful in steering patients to specific providers.

There are substantial differences among carriers in the reimbursement rates paid to healthcare providers. Reviewing the data using multiple methods allows for the identification of differences in contracting outcomes that have a dramatic impact on carrier competitiveness. Whether a carrier will remain competitive is affected in part by other factors beyond reimbursement contracts, but small differences in payment rates for medical services can have a substantial impact on a carrier. In this analysis, aggregate discounts are used to determine market competitiveness, with the simple average methodology and further breakdowns of data providing additional insight.

Methodology and Limitations

Data used for this analysis come from the NHCHIS using dates of service during calendar year 2011. Only New Hampshire providers are included, with members coming from New Hampshire or out of state. The distribution of carrier charges among product lines is shown in Appendix A.

Rates are provided only when the carrier had at least $1.5 million in provider charges.

Discounts are calculated by: (charges-total payments)/charges. Differences in payment levels are calculated by converting the discount rate to a percent of charges and calculating the difference as a percent of the lower paying carrier.

For example, Carrier A's discount is equal to 33 percent and Carrier B's is 21 percent:

1. Carrier A: 100% of charges – 33% discount = 67% of charges
2. Carrier B: 100% of charges – 21% discount = 79% of charges
3. 79 – 67 = 12 percentage points
4. 12/67 = .179 or 18%
5. Carrier B pays 18 percent more than Carrier A.

Connecticut General Life Insurance (CGLI) and Cigna are not treated as separate companies, and their data are combined under the name: CGLI/Cigna.

HPHC and Health Plans Inc. are combined under HPHC.

Anthem-NH and Matthew Thornton Health Plan are combined under Anthem.

Summarizing carrier discount rates is consistent with the purpose of this analysis, which is to determine if the discount rates show evidence of a competitive insurance market. However, health insurance is purchased locally, and summarizing charges and payments across the state will hide dramatic differences between a payer and any single organization. Hospital specific contract differences are likely to result in some carriers being unable to offer premiums to a specific employer at the same price as a competitor that has a more aggressive discount with the local hospital or delivery system. By analyzing the results at the state level, determinations can be made about a carrier's overall competitive position in the state, but not within communities. Unpublished NHID analyses have shown dramatic differences in payment rates among carriers and specific providers.

Self-funded accounts are included in these data with fully insured accounts, and the results include both types of accounts. In practice, there are likely to be differences between payment levels to some providers (particularly hospitals) for self-funded accounts, and typically the payment rate is higher for self-funded accounts. As a result, a

carrier's underwritten reimbursement discount rate may be larger than reported, and the discount applied to self funded members may be smaller than reported.

The discounts for prescription benefit medication costs were not included in this analysis due to data limitations. This is a significant portion of the premium for most accounts, and the prescription drug payment differences may give some carriers a competitive advantage.

Differences in the health status and medical care needs of populations can have a substantial impact on medical costs, and may explain why some carriers can sell health insurance at competitive premium levels, despite uncompetitive reimbursement contracts.

A similar service mix and use of providers is assumed among carriers. Carriers have a different share of the market in different parts of the state and different member health care needs, and these differences may impact the average discounts calculated.

This analysis reflects the claims data during the 2011 calendar year. To the extent that payments were made incorrectly, or were inconsistent with the terms of the provider-carrier contract, this analysis will not reflect contractual agreements. Patient liabilities, employer account charges (for self-funded accounts), and to some extent even premiums, will be based on the claims paid, regardless of carrier-provider contract terms.

The NHCHIS data used in this analysis does not include all commercial insurance payments made to New Hampshire providers for health care services. Patients obtaining health insurance out-of-state are not included.

Appendix A

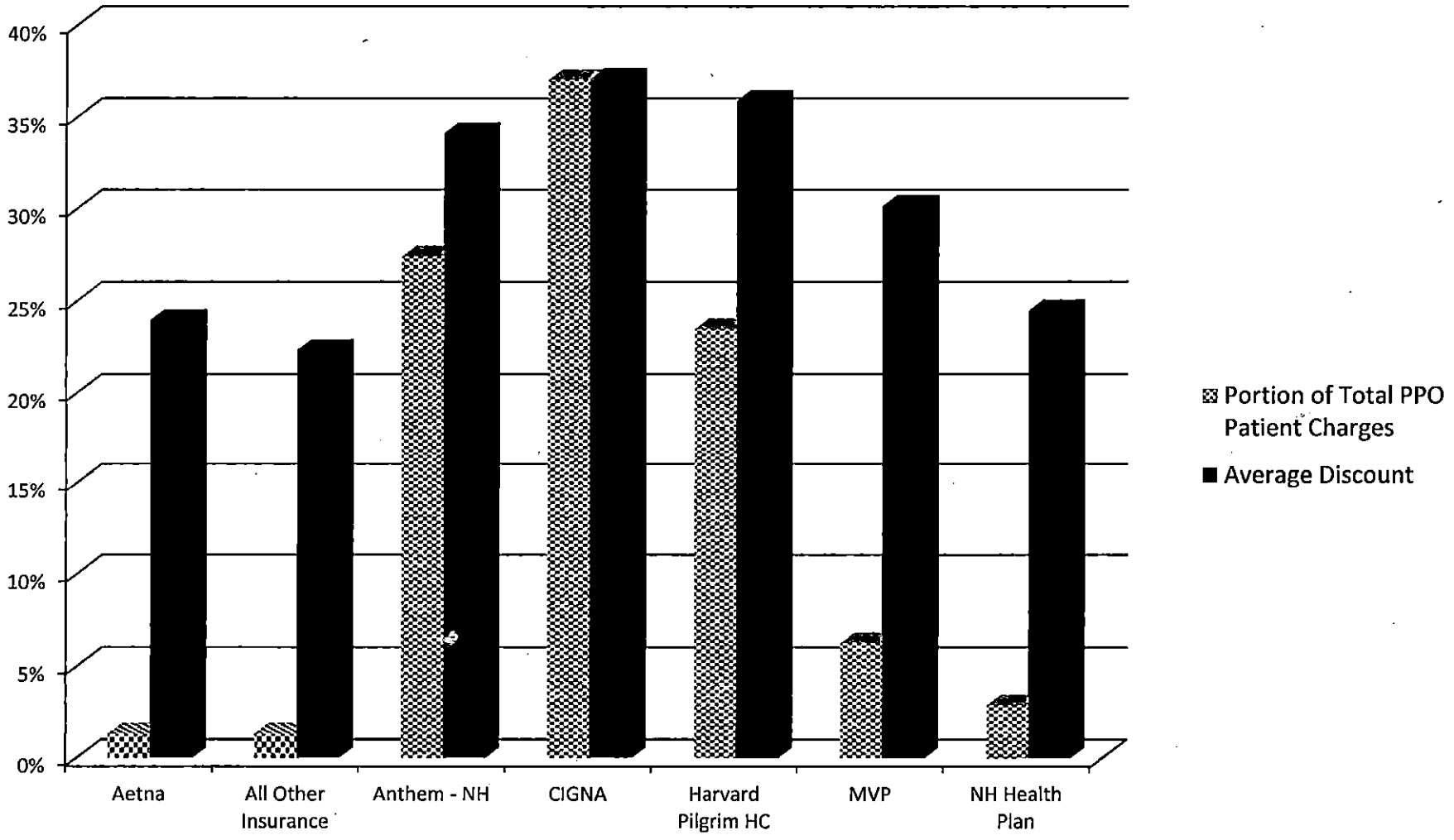
Carrier Product Distribution
Dates of service January 1, 2011 – December 31, 2011.

Company	Plan Type	Charges	Percent of Carrier's Provider Charges in Claims Database
Aetna	HMO	$2,147,763	1%
	Indemnity	$1,732,067	1%
	PPO	$16,277,477	8%
	POS	$185,942,639	90%
Total		$206,099,946	
All Other Insurance	Indemnity	$11,487,304	41%
	PPO	$16,465,280	59%
Total		$27,952,584	
Anthem - NH	HMO	$881,335,141	57%
	Indemnity	$29,378,612	2%
	PPO	$330,009,373	22%
	POS	$294,085,577	19%
Total		$1,534,808,703	
CIGNA	PPO	$445,998,526	96%
	POS	$18,853,328	4%
Total		$464,851,855	
Harvard Pilgrim HC	HMO	$407,389,483	57%
	PPO	$282,896,035	40%
	POS	$20,381,482	3%
Total		$710,667,000	
MVP	PPO	$75,544,715	100%
NH Health Plan	PPO	$34,817,887	100%
Tufts Insurance Co	HMO	$21,349,024	100%
United Healthcare	PPO	$2,786,486	17%
	POS	$14,099,355	83%
Total		$16,885,841	

Please direct questions or comments to Tyler Brannen, Health Policy Analyst: tyler.brannen@ins.nh.gov.

Tyler Brannen

Provider Discounts and Market Share for PPO Products in New Hampshire



Source: NHCHIS CY2011

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Tuesday, March 15, 2016

THE COMMITTEE ON Health and Human Services

to which was referred **SB 541**

AN ACT establishing a commission to study provider rates.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 3-0

AMENDMENT # 2016-1068s

Senator Molly Kelly
For the Committee

Kelly Flathers 271-3091

HEALTH AND HUMAN SERVICES

SB 541, establishing a commission to study provider rates.
Ought to Pass with Amendment, Vote 3-0.
Senator Molly Kelly for the committee.

New Hampshire General Court - Bill Status System

Docket of SB541

Docket Abbreviations

Bill Title: establishing a commission to study provider rates.

Official Docket of **SB541**:

Date	Body	Description
2/1/2016	S	**Introduced** 01/21/2016 and Referred to Health and Human Services; **SJ 3**
2/18/2016	S	Hearing: 03/01/2016, Room 101, LOB, 01:00 pm; **SC7**
3/17/2016	S	Committee Report: Ought to Pass with Amendment **#2016-1068s**, 03/24/2016; **SC 11**
3/24/2016	S	Committee Amendment 1068s, AA, VV; 03/24/2016 **SJ 10**
3/24/2016	S	**Ought to Pass with Amendment** 1068s, MA, VV; OT3rdg; 03/24/2016; **SJ 10**
3/29/2016	H	Introduced 03/23/2016 and referred to Health, Human Services and Elderly Affairs **HJ 27** P. 68
3/29/2016	H	Public Hearing: 04/07/2016 01:15 PM LOB 205
4/19/2016	H	Executive Session: 04/19/2016 10:00 AM LOB 205
4/21/2016	H	Committee Report: Inexpedient to Legislate for 05/11/2016 (Vote 16-1; CC) **HC 29** P. 12
5/11/2016	H	Inexpedient to Legislate: MA VV 05/11/2016 **HJ 38** P. 25

NH House	NH Senate

Other Referrals

SB 541

COMMITTEE REPORT FILE INVENTORY

X ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE AIDE AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

X **DOCKET (Submit only the latest docket found in Bill Status)**

X **COMMITTEE REPORT**

X **CALENDAR NOTICE**

X **HEARING REPORT**

X **PREPARED TESTIMONY AND OTHER SUBMISSIONS HANDED IN AT THE PUBLIC HEARING**

X **SIGN-UP SHEET(S)**

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

X - AMENDMENT # 2016-0796s
X - AMENDMENT # 2016-1068s
X - AMENDMENT # 2016-0995s
____ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

X AS INTRODUCED
____ AS AMENDED BY THE HOUSE
____ FINAL VERSION
X AS AMENDED BY THE SENATE

N/A **OTHER (Anything else deemed important but not listed above, such as amended fiscal notes):**

PLEASE INCLUDE THE COMMITTEE OF CONFERENCE REPORT HERE IF IT IS SIGNED BY ALL.

DATE DELIVERED TO SENATE CLERK

7/27/16

BY:

Kelly Feathers

COMMITTEE AIDE