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ATTORNEYS AT LAW

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D. Michael Frink
dmf@curtisthaxter.com

October 21 2005

Via Electronic Mail and
Hand Delivery by Courier
Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Dept. of Professional & Financial Regulation
34 State House Station
Augusta, ME 04333-0034

RE: **In Re: Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the First Assessment Year**
Docket No. INS-05-700

Dear Superintendent Iuppa:

Enclosed for filing in the above-captioned matter on behalf of the Maine Association of Health Plans ("MEAHP") please find the original and one (1) copy of the following documents:

1. Filing Cover Sheet

2. Prefiled Testimony of David A. Tobin (with exhibits);

3. Prefiled Testimony of Daniel Fishbein, M.D. (with exhibits).

Good faith estimate of time to present direct case and for cross examination.

MEAHP offers the following good-faith estimate of time for presentation of its direct case and for cross-examination of the witnesses of other parties. MEAHP has not yet had an opportunity to review the pre-filed testimony of the Dirigo Health Agency ("DHA"), nor of Consumers for Affordable Health Care ("CAHC"). MEAHP has also not yet received the pre-filed testimony or one or more witness to be called by the Maine State Chamber of Commerce. Until MEAHP has an opportunity to review this testimony, it is extremely difficult to provide an accurate estimate of time for either direct or cross examination.

Presentation of Direct Case. Subject to our review of all pre-filed testimony from other parties, we estimate that presentation of the direct case of MEAHP through our two witnesses

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MEMBER FIRMS OF THE GROUP PRACTICE INDEPENDENTLY AND NOT IN A RELATIONSHIP FOR THE JOINT PRACTICE OF LAW

will require approximately 5 to 10 minutes each. This estimate could increase to 20 minutes or more each, depending on the extent to which testimony of other parties' witnesses requires our witnesses to supplement their pre-filed testimony.

Cross examination. Subject to our review of the pre-filed testimony of the other parties, we estimate that cross examination by MEAHP will require for:

DHA witnesses (Schramm, Russell and Kane) approximately 15 minutes each for a total of 45 minutes;

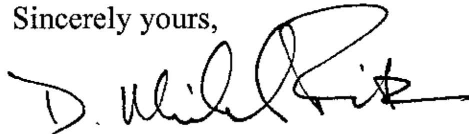
Maine State Chamber of Commerce witnesses (Sheils 15 minutes; Catterall 15 minutes; Mercier 10 minutes; Kenney 10 minutes) for a total of 40 minutes;

Anthem Blue Cross and Blue Shield witnesses (Roberts 15 minutes; Keane 10 minutes; McCormack 10 minutes; Whitmore 15 minutes; Wakelin 10 minutes) for a total of 50 minutes; and

Consumers for Affordable Health Care (Thorpe 15 minutes; Schramm/Kane 15 minutes; Wycke 10 minutes) for a total of 40 minutes.

Thank you.

Sincerely yours,



D. Michael Frink

DMF/lc
Enclosure
Cc: John Kelly (w/enc)
Thomas C. Sturtevant, Jr., Esq. (w/enc)
William H. Laubenstein, III, Esq. (w/enc)
Christopher T. Roach, Esq. (w/enc)
Rufus E. Brown, Esq. (w/enc)
Roy T. Pierce, Esq. (w/enc)
William H. Stiles, Esq. (w/enc)

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS)
DETERMINED BY DIRIGO HEALTH)
FOR THE FIRST ASSESSMENT YEAR)
)
Docket No. INS-05-700)

FILING COVER SHEET

TO: **Allessandro A. Iuppa, Superintendent**
ATTN: Vanessa J. Leon

Submitted by: D. Michael Frink

Date Filed: October 21, 2005

Party: Maine Association of Health Plans

Document: **Pre-filed Testimony of David A. Tobin, FSA, MAAA, FLMI, ACS, MHP, HIA (with Exhibits)**

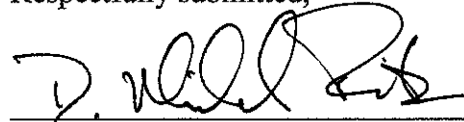
Pre-filed Testimony of Daniel Fishbein, M.D. (with Exhibits)

Document Type: Pre-filed Testimony

Confidential: No

Dated: October 21, 2005

Respectfully submitted,



D. Michael Frink (Bar No. 2637)
CURTIS THAXTER STEVENS BRODER
& MICOLEAU LLC
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CERTIFICATE OF SERVICE

I hereby certify that on this date the foregoing document was served on the following parties via electronic mail and courier hand delivery:

Alessandro A. Iuppa, Superintendent
Attn: Vanessa J. Leon, Docket No. INS-05-700
Bureau of Insurance
Maine Department of Professional and Financial Regulation
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Attn: John Kelly
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jck@compass-inc.com

Thomas C. Sturtevant, Jr.
Assistant Attorney General
Office of the Attorney General
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I further certify that the foregoing documents were served on counsel of record in this case via electronic mail only, as follows:

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Dated: October 21, 2005

D. Michael Frink, Bar No. 2637

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NON-CONFIDENTIAL

STATE OF MAINE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

BUREAU OF INSURANCE

IN RE:	)	EXHIBIT ___
	)	
REVIEW OF AGGREGATE	)	
MEASURABLE COST SAVINGS	)	PREFILED TESTIMONY OF
DETERMINED BY DIRIGO HEALTH	)	DANIEL FISHBEIN, M.D.
FOR THE FIRST ASSESSMENT	)	
YEAR	)	
	)	
Docket No. INS-05-700	)	***October 21, 2005***
	)	

1 **I. Introduction and Overview.**

2 **Q. Please state your name and your position with Aetna.**

3 A. My name is Daniel R. Fishbein. I am currently the Head of Aetna's national Health Plan
4 Alliances business, and I am based in the company's Portland, Maine office. I attach as Fishbein
5 Exhibit 1 a Biosketch that details my background and experience in the healthcare field. I can
6 say that, in general, I am very familiar with our products, provider network, and customers in
7 Maine.

8 **Q. For whom are you testifying?**

9 A. Aetna and the Maine Association of Health Plans ("MEAHP").

10 **Q. What is the Maine Association of Health Plans?**

11 A. The Maine Association of Health Plans is the trade association that represents the
12 administrators of self-funded and fully insured health benefit plans in the State of Maine. The
13 members of the Association are Aetna Health, Inc, Anthem Blue Cross/Blue Shield of Maine,
14 CIGNA HealthCare of Maine, Inc. and Harvard Pilgrim HealthCare. Collectively, health plans
15 under the administration of MEAHP members cover approximately 665,000 Maine people.

16 **Q. How did you prepare for your testimony?**

17 A. I have reviewed various materials related to these proceedings including the Mercer
18 Report, the Lewin Report, Aetna DRG data for Maine, Aetna medical costs trends for Maine, the
19 so-called Dirigo law enacted by the Maine Legislature in 2003 (and amended earlier this year)
20 and draft pre-filed testimony submitted by Anthem Blue Cross/Blue Shield. Also, MEAHP is
21 sponsoring, with the Maine State Chamber of Commerce, the testimony of Mr. John Shiels of the
22 Lewin Group, and I have reviewed his prefiled testimony. I have also spoken with Aetna's

1 network operations personnel in Maine to determine whether they have noticed any impact
2 resulting from the various Dirigo initiatives discussed in this case.

3 **Q. Please indicate the purpose of your testimony.**

4 A. First, Aetna supports the goals of the so-called Dirigo law in attempting to reduce the
5 number of uninsured and underinsured people in Maine. In addition, Aetna supports the State in
6 any efforts to reduce healthcare costs to employers and individuals in Maine. However, both of
7 these goals cannot always be achieved at the same time and with the same program. Presently,
8 we have not yet experienced actual savings resulting from the operations of the Dirigo Health
9 Agency ("DHA") to pass back to the program. In order for this process to make sense for
10 employers and consumers and to be a sustainable program, we need to be careful to only apply
11 realized savings to fund DHA's insurance operations.

12 In my testimony, I will discuss MEAHP's position on how the savings should be
13 calculated under the Dirigo law and whether the filing made in this case by the DHA meets the
14 requirement of the law. I will summarize the specific flaws in the DHA savings determination
15 identified by MEAHP, and I will discuss several of these flaws in detail. Another MEAHP
16 witness, David Tobin of CIGNA, will submit testimony from his standpoint as an actuary
17 working in the health insurance field regarding other specific problems with DHA's savings
18 calculation.

19 In addition I will present information regarding medical costs incurred in Aetna's Maine health
20 plans, medical cost trends in Maine and Aetna's network operations in Maine. Based on this
21 information, I offer my conclusion that Aetna and its customers have not realized any of the
22 hypothetical cost savings as outlined in the Mercer report.

1 **Q. Do you believe that DHA's savings calculation represents a reasonable approach to**
2 **determining savings?**
3 A. No, I do not. The primary reasons for my conclusion are as follows:
4 (a) DHA claims credit for savings that, even if they could be measured, were clearly not
5 the result of the *operations* of DHA;
6 (b) DHA has failed to show that any of the savings that it claims providers have enjoyed
7 have in fact been passed on to health plan administrators in the form of charges that are
8 lower than they would otherwise have been; and
9 (c) none of these alleged savings have been realized by Aetna or our health plan
10 purchasers (employers and members) in Maine.
11 **Q. What would be the result if the Superintendent establishes a level of aggregate and**
12 **measurable cost savings in excess of the savings actually realized by the plans due to the**
13 **operations of DHA?**
14 A. My understanding is that the basis for making a Savings Offset Payment ("SOP") to
15 DHA was that, prior to payment of any SOP assessment, (a) DHA's *operations* would have
16 generated actual savings for providers, and (b) those providers would have actually passed those
17 savings along to the carriers in the form of lower charges covered by the carriers. After all, the
18 purpose of the Savings *Offset* Payment is to offset savings. If the SOP is greater than the actual
19 savings, then the net effect is an *increase* in total costs.
20 Moreover, as Mr. Tobin of CIGNA, Ms. Roberts of Anthem and Mr. Shiels of the Lewin
21 Group all explain in their testimonies, it is generally accepted in the industry that each increase
22 in health insurance rates causes some percentage of the existing base of insured people to drop or
23 lose coverage. Since carriers have not realized any of these hypothetical DHA-generated
24 savings, approval of DHA's savings calculation means that carriers operating in Maine will be

1 required to increase premiums in order to reflect an inappropriate SOP. This would undoubtedly
2 result in some Maine people losing their health insurance as a result of DHA.
3
4 ## II. The SOP Must Be Limited to Savings Resulting from DHA's Operations.
5
6 **Q. What is MEAHP's position regarding the calculation of "aggregate measurable**
7 **savings?"**
8 A. MEAHP's attorneys have advised us that under the Dirigo law, DHA can only claim
9 savings that result from its "operations," and from the expansion of MaineCare enrollment. They
10 further advise that by "operations," the Legislature meant to capture only the savings passed
11 along to carriers by DHA's insurance offerings. These savings would occur to the degree that
12 DHA's insurance program changed the ratio of uninsured (and under-insured) versus insured
13 patients visiting hospitals and other providers for care. This would theoretically result in a
14 reduction of bad debt and charity care costs incurred by Maine hospitals. If the providers in fact
15 experienced such reductions due to DHA's insurance, and if the providers then passed those
16 reductions along to the plans in the form of lower charges, then one could say that DHA's
17 operations had produced savings, in turn justifying an SOP.
18 **Q. What is your understanding as to what DHA must show in order to sustain its**
19 **savings calculation?**
20 A. It must establish that Maine health plan administrators have experienced aggregate
21 measurable cost savings passed along to them by healthcare providers who have funded the
22 reduced charges out of reductions in bad debt and charity care-related costs directly resulting
23 from (a) DHA's *operations*—that is, resulting from the healthcare coverage that it offers—and
24 (b) the expansion of MaineCare enrollment. The savings level so established then becomes a cap

1 on the SOP assessment which DHA may levy. The actual SOP assessment gets determined in a
2 subsequent proceeding before DHA and is supposed to be based on the criteria established in the
3 law, and on certain savings-related reports called for in the law.

4 In addition, I have reviewed a handout, attached as Fishbein Exhibit 2, distributed by the
5 Governor's Office of Health Policy and Finance dated June 11, 2003. It was distributed at the
6 time of the floor vote in the Legislature on the Dirigo law and it explains the Governor's Dirigo
7 proposal to Maine's Legislators and the public generally. The second page of the handout
8 contains a five-point explanation of how the subsidies built in to DHA's healthcare coverage will
9 be financed. The third and fourth points are consistent with my understanding of what DHA
10 must show:

11 • Capture realized savings *from the reduction in bad debt and charity care* through
12 savings offset payments by health insurance carriers, third-party administrators,
13 and employee benefit excess insurance carriers. Payments will be made by
14 insurers to Dirigo Health <u>only</u> after savings are shown. Insurers' payments will
15 offset savings so payments will never exceed the savings

16 • Use the savings offset payments to fund premium subsidies of those with incomes
17 above MaineCare eligibility and below 300% of the federal poverty level after the
18 first year and to fund the Maine Quality Forum

19 **Q. Has DHA limited the scope of its savings calculation to cover only realized savings**
20 **from the reduction in bad debt and charity care?**

21 A. No. In fact, the only category of savings identified in DHA's September 19 filing that
22 meets this criterion can be found in the "Uninsured/Under-Insured Initiatives" section of DHA's
23 September 19 filing. These savings, as calculated by DHA, amounted to $5.7 Million.
24 Mr. Shiels' testimony discusses the particular problems with DHA's methodology for measuring
25 savings from reductions in bad debt and charity care. Suffice it to say that Aetna has realized

1 little or no savings from this source. Beyond that, according to DHA's own statistics, only 22%
2 of the 8,000 plus Dirigo members were previously uninsured.
3 The rest of the savings proposed by DHA have nothing to do with its "operations," and in
4 any event are well outside the bad debt/charity care/MaineCare-enrollment-based savings
5 analysis identified as the source of savings in the material distributed by the Governor's Office
6 that I referred to above. It is MEAHP's position that these other categories of savings should
7 never have been included in DHA's savings calculation, and that the Superintendent should
8 disregard them.
9

10 III. Alleged Savings from the "Part F Requests" Should Not Be Included in 11 Any Calculation of Savings Generated by DHA's "Operations".

12

13 **Q. In the 2003 law that launched DHA, the Legislature asked for a series of voluntary**
14 **cost and price limits for the Maine healthcare market. Could you comment on these items?**
15 A. Yes. In Section 1 of Part F of the 2003 law, the Maine Legislature asked healthcare
16 practitioners, hospitals and health insurance carriers to adopt certain voluntary limits on cost
17 growth. Section 1 states that the purpose of these requests was "to control the rate of growth of
18 costs of healthcare and health coverage."
19

20 **Q. What is MEAHP's position on the propriety of DHA's inclusion of supposed savings**
21 **from these initiatives in the savings calculation?**
22

23 A. As I stated earlier, MEAHP's attorneys have advised us that the statute that describes the
24 savings from which the SOP is to be determined limits the savings calculation to the savings
25 resulting from DHA's "operations," and that any savings that may have resulted from the

1 Legislature's request, in 2003, that Maine healthcare providers (and others in the system) limit
2 their charges cannot be included in a calculation of savings resulting from DHA's "operations."
3 Again, this is an issue of statutory construction that I am not qualified to discuss.

4 IV. Impact on Aetna in Maine from DHA Operations.

5 **Q. What is Aetna's market position in the Maine health insurance market?**
6 A. Aetna has 89,520 members in various types of health plan products including HMO and
7 PPO plans. Most of these plans are provided by 3,209 employers to their employees in Maine.
8 Aetna contracts with 39 hospitals in Maine and 2,698 Maine physicians. Last year, Aetna
9 processed ___ healthcare claims for Maine residents and paid _________for those claims. Aetna
10 collected $195,332,000 in premiums from its Maine operations in 2004. In addition, Aetna has
11 an office in Maine and employs 202 Maine residents.
12 **Q. Have you reviewed Mr. McCormack's testimony regarding the process of hospital**
13 **negations in Maine?**
14 A. Yes.
15 **Q. Do you agree with his conclusions regarding the difficulty of reducing or limiting**
16 **hospital rate increases in a contract negotiation?**
17 A. Yes
18 **Q. Have you reviewed Mr. McCormack's testimony regarding the process of**
19 **negotiations with physicians in Maine?**
20 A. Yes.
21 **Q. Do you generally agree with his conclusions?**
22 A. Yes.

1 **Q. In his testimony, Mr. McCormack states that Anthem enters into multi-year**
2 **agreements with providers that affect the flow-through of cost savings to plans. Do you**
3 **agree with this point?**
4 A. To some extent. Since negotiations do not occur annually but instead take place every
5 few years, we do not have an annual negotiation process where we try to obtain additional
6 negotiated discounts with providers including any alleged savings generated by Dirigo. Even if
7 we did have an annual negotiation, however, I do not think it would make much difference in our
8 ability to obtain savings from hospitals based upon alleged savings generated by Dirigo.
9 **Q. Why is that?**
10 A. As Mr. McCormack and Mr. Keane explain in their testimonies, Maine plans almost
11 universally negotiate percentage-of-charges contracts with hospitals. This results in negotiated
12 payments for provider services generally being below providers' usual and customary charges
13 and rates. If a hospital would have set its charges at "Level X," but instead sets its charges at
14 Level X minus 5% as a result of DHA's operations, then the reduction in charges (and the
15 commencement of savings) would be effective as of the date that the new, lower charges went
16 into effect (not when the agreement is renegotiated). This is the point that Mr. McCormack
17 makes in his testimony when he states that percentage of charge contracts (which he refers to as
18 "discount off charge" contracts) only yield savings when the hospitals in fact lower their charges.
19 Since July of 2003, we have seen a few hospitals temporarily lower their charges.
20 However, Aetna has seen no net reduction in hospital charges either from these particular
21 hospitals, or from Maine hospitals in general.
22 Mr. Keane's data shows that in fact Maine's hospitals are increasing their prices at a rate
23 that substantially outstrips the cost increases they are experiencing—a point that renders DHA's
24 hospital-cost-based approach to determining savings invalid per se.

1 **Q. Are there any regulatory constraints that MEAHP members have encountered in**
2 **seeking favorable arrangements with Maine hospitals?**
3 A. Yes. In Maine, the requirements of Rule 850 obligate health plans to include virtually all
4 hospitals, doctors and other providers in their networks, which largely eliminates the ability of
5 health plans to exert any leverage in these negotiations.
6 **Q. Can you indicate whether Aetna has made progress recently in its negotiations with**
7 **Maine hospitals?**
8 A. While we do not re-negotiate provider contracts with each Maine hospital every year,
9 there have been a substantial number of renegotiations so far in the first ten months of this year.
10 So far this year we have re-negotiated contracts with 15 of the 39 hospitals in Maine. In eight of
11 these negotiations, the resulting terms were less favorable than they were in the prior agreement,
12 in three they are better, and in four they stayed about the same.
13 In addition, as I mentioned previously, all of these contracts give the hospitals the ability
14 to increase their underlying charges against which the negotiated discounts are applied.
15 **Q. Have any of the hospitals in your network increased their charges?**
16 A. In virtually all of our hospital relationships, the hospitals have increased their underlying
17 charges this year.
18 **Q. What are Aetna's overall medical cost trends in Maine since the first quarter 2004?**
19 A. Overall, Aetna's net medical cost trends in the first quarter 2004 were 7% above the first
20 quarter in 2003. The latest quarter for which data is available, the third quarter of 2005, has a net
21 trend of 9% above the third quarter in 2004. Aetna and its customers have not seen any
22 reduction in its medical cost trends since 2004 and its most recent trend does not indicate any
23 reduction in medical cost for Maine residents. Based upon this information Aetna has not
24 realized any of the assumed, hypothetical savings submitted by the DHA and in fact medical cost
25 trends are increasing year to year.

1 **Q. Have Aetna's hospital costs gone up in Maine in the last year?**

2 A. Aetna's hospital costs on both a per-day and per-admit basis for the 6/30/2004 to
3 7/1/2005 ("2004-05 time period") time period showed a substantial increase over the costs
4 observed in the previous twelve-month period (from 6/30/2003 to 7/1/2004, "2003-04 time
5 period"). On a per-admit basis, hospital costs for the top 25 DRGs in Maine increased 8.8%
6 from 2003-04 time period to the 2004-05 time period. The same top 25 DRGs increased 5.4%
7 on a per-admit basis from 6/30/2002 to 7/1/2003 ("2002-03 time period") to 2003-04 time
8 period. Therefore, not only have the costs increased but also the rate of increase has gone up,
9 not down in the last year. In addition, Aetna has seen an upward trend in amounts incurred for
10 the top 25 DRGs on a per day basis. The 2004-05 time period per day paid amounts were 10.2%
11 above the same DRGs for 2003-04 time period. This is more than the 7.1% increase sustained
12 from 2002-03 time period to 2003-04 time period.

13 **Q. How does this compare with the national trend?**

14 A. If you refer to Tobin Exhibit 1, attached to Mr. Tobin's testimony, you will see that the
15 trend has been moving in just the opposite direction on a national basis.

16 **Q. What conclusion do you draw from this information?**

17 A. Not only have hospital costs gone up in Maine in the last year on both a per-admit and a
18 per-day basis, but the rate of increase is higher than in the previous period.

19 **Q. Does this conclude your testimony?**

20 A. Yes, it does.

Fishbein Exhibit 1

Biosketch of Daniel Fishbein, M.D.

Dan is Head of Aetna's national Health Plan Alliances business, and is based in the company's Portland, Maine office. Health Plan Alliances consists of various businesses that provide services to other health plans and includes HMS Healthcare of which Dan is President. HMS Healthcare provides network and medical management services in Michigan, Colorado, and several other states and includes the PPOM and Sloans Lake managed-care subsidiaries. Health Plan Alliances also includes the Aetna Signature Administrators business which provides services to large Third Party Administrators. Dan is also responsible for the company's Student Health business which provides college sponsored health plans to more than 120 colleges and universities across the country and currently serves 365,000 students. The Student Health business is operated through The Chickering Group which is the largest provider of Student Health plans in the country and is based in Cambridge, MA. Dan is the President of The Chickering Group.

Previously, Dan was also responsible for Product Development for the Key Accounts segment across the country. In 2002, Dan led the Select and Key Accounts business segment in New England and Upstate New York, with overall business responsibility for the middle market (employers from 50 to 3,000 workers) in Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont and Upstate New York. Dan was also a member of Aetna's National Strategy Council, under the direction of the Office of the Chairman.

From 1998 to 2001, Dan was General Manager and had overall responsibility for business in Maine. This included over 100,000 health plan members. During 2001, Dan was part of a six-person team that developed the strategy for the "New Aetna". From 1995 to 1998, Dan was president and CEO of NYLCare Health Plans of Maine, and the regional executive responsible for NYLCare's New England region. NYLCare of Maine was a start-up health plan that grew rapidly from inception to 60,000 members and was a part of New York Life's NYLCare Health Plans subsidiary. Aetna purchased NYLCare in 1998.

From 1990 to 1995, Dan was Vice President and an executive officer of New York Life, responsible for the Product Development and Managed Care divisions of Group Benefits. From 1985 to 1990, Dan was with the Massachusetts Mutual Life Insurance Company in Springfield, MA where he held several positions, including Second Vice President, healthcare product development and managed care.

Dan received his B.A. degree magna cum laude and his M.D. from Boston University.

6/11/2003

Dirigo Health

Dirigo Health will make quality, affordable health care available to every Maine citizen and initiate new and important processes for cost containment and quality improvement.

Access

- Dirigo Health offers Dirigo Health Insurance through private insurance carriers to individuals, small business (<50 employees) and the self-employed – enrollees benefit from lower and more stable rates provided by participation in a larger group
- Universal access to affordable and quality health care is achieved in 5 years
  - MaineCare is expanded to cover more low income citizens: to 125% FPL for individuals and 200% FPL for adults with MaineCare eligible children
  - Individuals, families, small business employees and the self-employed with incomes below 300% FPL are eligible for subsidies to help pay Dirigo Health Insurance premium costs on a sliding scale based on ability to pay – up to $27,000 in income for an individual and $55,000 for a family of 4 (see attachment for Access narrative)

Quality Improvement

- Maine Quality Forum is established – a quality watchdog for Maine providing more public information about costs and quality of health care
  - MQF will collect and disseminate research, adopt quality and performance measurers, issue quality reports, promote evidence based medicine and best practices, encourage adoption of electronic technology, make recommendations to the State Health Plan

Cost Containment

- Commission to Study Maine's Hospitals
  - Examine hospital costs and expenditures, impact on local economies, opportunities for hospital coordination in health care delivery and efficiency, improve planning for capital improvements, etc.

Governor's Office of Health Policy and Finance
15 State House Station, August, ME 04333-0015
Ph: 624-7442 * Fax: 624-7608
GOHPF@maine.gov

- Biennial State Health Plan to assess need and available resources, set statewide goals for health care access and establish a budget for planning statewide expenditures
- One year voluntary caps on cost and operating margin of insurers, hospitals and providers to inform State Health Plan
- Capital Investment Fund is created to place capital expenditures on a budget – ensures wise and appropriate allocation of resources but ends the medical arms race
    - One year CON moratorium (from May 5, 2003) to inform Capital Investment Fund planning
    - Expand CON to ambulatory surgery centers and doctors offices for investments in new technologies costing over $1.2 million and capital expenditures over $2.4 million
- Require small group health plans to submit rate filings to the Superintendent of Insurance for review and approval and strengthened oversight of the large group market

Financing

- Drawdown additional federal Medicaid dollars by expanding Medicaid eligibility
- Use the employers' share of Dirigo health insurance premiums for Medicaid eligible individuals to pay state share of Medicaid expansion
- Capture realized savings from the reduction in bad debt and charity care through savings offset payments by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers. Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings
- Use the savings offset payments to fund premium subsidies of those with incomes above MaineCare eligibility and below 300% of the federal poverty level after the first year and to fund the Maine Quality Forum
- Use about $52 million one time federal fiscal relief monies to fund the first year premium subsidies and about $1 million to fund the Maine Quality Forum

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STATE OF MAINE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

BUREAU OF INSURANCE

IN RE:	)	EXHIBIT ___
	)	
REVIEW OF AGGREGATE	)	
MEASURABLE COST SAVINGS	)	PREFILED TESTIMONY OF
DETERMINED BY DIRIGO HEALTH	)	DAVID A. TOBIN, FSA, MAAA,
FOR THE FIRST ASSESSMENT	)	FLMI, ACS, MHP, HIA
YEAR	)	
	)	***October 21, 2005***
Docket No. INS-05-700	)	
	)	

1 **I. Introduction and Overview.**

2 **Q. Please state your name and your position and describe your background and**
3 **qualifications.**

4 A. My name is David A. Tobin and I am employed by CIGNA Healthcare in Bloomfield,
5 Connecticut where I am an Actuarial Senior Director. In this position, I am responsible for
6 nationwide medical pricing of plans for employers with more than 200 subscribers. (This
7 includes those CIGNA plans in Maine that fall into this category.) I hold a Bachelor of Science
8 degree (with High Distinction in Actuarial Science) from the University of Illinois – Champaign
9 and have been employed as an actuary for over twelve years. I am a Fellow of the Society of
10 Actuaries, a Member of the American Academy of Actuaries, and a Fellow of the Life
11 Management Institute. I live in Avon, Connecticut.

12 **Q. How did you prepare for your testimony?**

13 A. I have reviewed various materials related to these proceedings including the Mercer
14 Report and the prefiled testimony of Sharon Roberts, Jack C. Keane and Daniel P. McCormack
15 submitted by Anthem Blue Cross/Blue Shield ("Anthem"). I have also reviewed the prefiled
16 testimony filed in this proceeding by John Shiels of the Lewin Group. (Mr. Shiels' testimony is
17 being jointly sponsored by the Maine State Chamber of Commerce and Maine Association of
18 Health Plans ("MEAHP").) I am also specifically familiar with provider cost data and medical
19 cost trends for Maine.

20 **Q. Please indicate the purpose of your testimony.**

21 A. The Dirigo Health Agency ("DHA") is seeking authority to assess CIGNA and other
22 members of the MEAHP with Savings Offset Payments ("SOP") equal to as much as four
23 percent (4%) of our paid claims in Maine. In this testimony, I explain that the savings claimed

1 by DHA are illusory in that (a) they cannot be separated from national and local medical cost
2 trends, and (b) DHA admits that it cannot show that the savings calculation that it has put
3 forward in fact captures only those savings attributable to DHA (if any), as the law appears to
4 require. In addition, I offer my opinion as a healthcare actuary that the methodology used by
5 DHA's consultants of only including data from certain hospitals in the case mix adjusted
6 discharge ("CMAD") calculation is contrary to fundamental actuarial principles. I also testify
7 that factors such as utilization trends and the underwriting cycle could have a greater impact than
8 any conceivable impact resulting from DHA's operations. Finally, I explain that any assessment
9 on Maine's private health insurance carriers under consideration in this proceeding will have to
10 be passed on to our subscribers in the form of higher health insurance premiums. To the degree
11 that the SOP assessment exceeds actual savings, then the likely impact of the Dirigo program
12 will be to increase, not reduce, the number of uninsured Maine citizens—a result precisely
13 contrary to what I understood the Maine Legislature sought to accomplish.

14 II. Identifying DHA's Impact on Maine Medical Cost Trends.

15 **Q. As an actuary, do you believe that it is possible to objectively determine the impact**
16 **of the operations of DHA on medical costs in Maine?**

17 A. No, I do not. Total state medical costs are in the billions of dollars and are affected by
18 many economic and regulatory aspects and influences. Among the most significant of the
19 economic influences is the level of general inflation in the economy. This is the prime driver of
20 wages, expenses and general operating costs incurred by healthcare providers everywhere.
21 Beyond that, the underwriting cycle (which I discuss later in my testimony) can have a greater
22 impact on future costs than anything DHA might accomplish.

1 **Q. Why is this especially significant in this case?**

2 A. Looking at this on a nationwide basis, we see that healthcare cost trends increased
3 steadily from the mid-nineties through the year 2002. After 2002, the national trend decelerated
4 significantly. This is illustrated in Tobin Exhibit 1, which is attached to this Testimony. Tobin
5 Exhibit 1 is a chart prepared by CitiGroup for its 2006 Health Benefits Survey, which was
6 released on October 11, 2005. Any study undertaken for the purpose of identifying the influence
7 of a single factor (here, DHA's operations) on overall healthcare spending would have to
8 carefully control for, and thus take into account, this general trend.

9 **Q. The chart that constitutes Tobin Exhibit 1 also seems to demonstrate that premium**
10 **yield growth exceeds medical cost growth in some years, tracks it in others, and actually**
11 **falls below it in some years. Could you comment on this?**

12 A. Yes. The chart nicely illustrates what is widely known in the industry as the
13 "underwriting cycle." In the first phase of the cycle, insurers incur claims in excess of their
14 estimates, causing them to raise premiums. After a period of recoupment, insurers enjoy a period
15 of profitability. In the final phase, insurers begin under-pricing their competitors to capture
16 additional market share, driving premiums down and thus re-starting the cycle. Looking at the
17 chart, we see that premium trends exceeded medical cost trends in the early nineties, but declined
18 steadily, plunging below medical cost trends in 1996, before rising again through 2002. In my
19 opinion, this shows that the underwriting cycle has a profound influence on health insurance
20 premiums.

1 **Q. Did the Mercer Group in fact attempt to distinguish the impact of DHA's operations**
2 **on Maine healthcare costs versus all other factors?**

3 A. No. In fact, I believe that they determined that this objective was simply not attainable
4 within the constraints resulting from the deadlines in the Dirigo law. I have been furnished with
5 a copy of the Minutes of an August 2 meeting of the Working Group set up by the Maine
6 Legislature in the 2005 amendment to the Dirigo law. This is the Group that was charged with
7 developing a methodology for determining savings generated by DHA's operations, but could
8 not reach agreement. According to these minutes, Mr. Schramm of the Mercer Group made a
9 presentation on the Mercer analysis and then took questions from Working Group members.
10 One Working Group member asked the "$64,000 Question," and Mr. Schramm stated that
11 Mercer made no distinction between DHA-related savings and savings stemming from other
12 sources:

13 Q: How does one determine where savings come from?
14 Ans: After some review of the savings initiatives to see if the savings are
15 connected to the Dirigo Health Act and after reviewing the Savings Offset
16 Payment process where the actual payment represents only a portion of the
17 savings estimated, Mercer chose an approach that did not separately identify
18 savings associated with the Dirigo Health Act. Mercer indicated that if more data
19 was forthcoming and if time permitted, then a more precise calculation could
20 theoretically be made.
21
22 Thus, Mercer appears to have conceded that its analysis did not distinguish DHA-related savings
23 from other factors influencing costs because it could not do so within the time and data
24 constraints presented. Mr. Keane, Anthem's hospital cost consultant, concurs in Mercer's
25 position that no such determination could be made under these constraints, as do I. In fact, as I
26 stated earlier, I believe it would be very difficult to attribute discrete healthcare cost savings to

1 DHA even if one had unlimited time and ample data. Of course, this is one of the points
2 Mr. Shiels of the Lewin Group makes in his testimony, wherein he outlines a possible procedure
3 that one could pursue to try to establish the actual savings generated by DHA.

4 **Q. Did Mercer in fact take more time and review additional data?**

5 A. I am not aware of any further refinement to the Mercer analysis. Moreover, I question
6 whether any study, no matter how sophisticated, could determine the discrete savings generated
7 by a single source or set of sources. Mr. Schramm stated as much at the August 2 meeting
8 (again, according to the minutes I have reviewed):

9 Q: In regard to the CMAD [Case Mix Adjusted Discharge] - Savings are
10 identified as attributable to Dirigo, as are changes in the severity of illness.
11 However, there are quality initiatives developed by carriers and others in the
12 State. How can the changes in severity be attributed to Dirigo only?
13 Ans: It is not certain one can differentiate between CMAD changes already in
14 the works versus new initiatives that may have been undertaken during the time
15 period of the baseline. Further, given the timing and the lack of baseline data, it
16 is probably impossible to say whether CMAD improvement is a result of
17 initiatives before 2004 as opposed to 2004 and later.
18

19 Here again, Mr. Schramm states that Mercer had neither the time nor the data sufficient to
20 distinguish DHA-related savings from other savings. This is especially significant when one
21 considers that the savings supposedly stemming from the "Hospital Initiatives," which the
22 CMAD technique was supposed to determine, constitute $75 million of DHA's total savings.

1 **Q. Should any savings resulting from the so-called "Hospital Initiatives" be included in**
2 **the calculation of the SOP?**

3 A. No. As a threshold matter, we have the issue of whether Hospital Initiative savings
4 should be included in the calculation at all. MEAHP's attorneys have advised us that under the
5 law that the Superintendent must apply in this case, the total savings calculation, which
6 establishes one of the caps on the SOP, is supposed to reflect only savings from the reduction of
7 bad debt and charity care caused by the operations of Dirigo, and the savings resulting from an
8 expansion of MaineCare. (MEAHP will be addressing this issue in depth in the Brief that we
9 will file on Monday, October 24.)

10 Anthem's witness, Jack Keane, also addresses this issue. He agrees that only savings
11 generated by the "operations of Dirigo" or resulting from increased MaineCare enrollment
12 should be included in the SOP calculation. He separately points out that the law does not state
13 that savings accruing from the voluntary cost restraints requested by the Legislature in 2003
14 should be attributed to DHA.

15 This issue is one of statutory interpretation and is therefore not within the scope of my
16 testimony.

17 However, even if the Superintendent decides that the Hospital Initiatives can be included
18 in the overall savings calculation, I agree completely with the point made by Mr. Keane in his
19 testimony that the CMAD measure, as used by DHA in this case, only seeks to measure the
20 degree to which certain hospitals recorded a CMAD that was less than the "expected amount," as
21 determined by DHA. Under DHA's approach, it has attributed 100% of the "delta" between the
22 actual and expected amount to DHA's operations. As Mr. Keane points out, DHA's consultants
23 have made no effort to determine whether any portion of this delta can be "explained," as a
24 statistician would say, by DHA's operations.

1 In summary, DHA's proposed savings determination is neither *aggregate* (since it
2 excluded a significant portion of the data) nor *measurable* (since it did not statistically verify the
3 savings attributable to DHA's operations).

4 **Q. DHA analysts claim to have measured the impact of DHA's operations through the**
5 **CMAD measure. Do you agree with the approach they used?**

6 A. No. Obviously, if the Superintendent agrees with MEAHP's and Mr. Keane's view that
7 SOPs should reflect only savings from the reduction of bad debt and charity care (plus the impact
8 of expanded MaineCare enrollment) then this measure cannot be used, since it makes no
9 distinction between savings accruing from one source versus any other.
10 Even if one were to agree that all hospital cost reductions should be attributed to DHA,
11 however, the Mercer analysis committed a fundamental error that renders their results unusable:
12 as Mr. Shiels and Mr. Keane point out, the DHA study only included data from hospitals where
13 the cost per CMAD beat expectations, while excluding data from hospitals that did not. This, in
14 my opinion, violates a core actuarial principle, since the study reflects only favorable data while
15 excluding unfavorable data. To obtain a reasonable and acceptable study, one would either have
16 to include all data from all of Maine's hospitals or else develop a balanced and unbiased sample
17 of the available data.

18 **Q. Did CIGNA in fact observe any cost reductions from hospitals during the "savings**
19 **year" currently under review?**

20 A. We noticed a slight easing of cost increases from Maine hospitals during this period. It is
21 not clear that these mild trend reductions were the result of DHA and not a result of some of the
22 other dynamics I previously discussed. If significant DHA-generated savings did in fact occur,
23 the hospitals do not appear to have passed more than a small portion of them on to us. In fact,

1 our provider contracting staff has heard directly from hospitals that their savings resulting from
2 reduced bad debt and charity care have been largely offset by expansions in MaineCare.

3 **Q. Why would an expansion of MaineCare offset bad debt and charity care cost**
4 **savings?**

5 A. Because MaineCare does not pay the full cost of the care being provided. This produces
6 the "cost shift" to commercial payors (such as my company) and their subscribers.
7 In any event, even if the providers actually pass along the entire amount of this minimal
8 cost relief, any benefit that the plans actually get will be totally overwhelmed if the DHA levies
9 an SOP assessment on us.
10 Our network contracting area has advised that a further slight softening in hospital
11 charges may be coming based on what he has seen in negotiations currently under way, but this
12 would not be reflected in the period under review in this case. (Meanwhile, we have seen
13 minimal softening on the physician side of the equation.)
14 I would point out that in general, (a) hospital costs tend to be about 50% of our total
15 claims, and (b) a hospital's prices tend to affect about 50% of what hospitals charge us (the other
16 50% of hospital charges being accounted for in utilization). Using this rule of thumb, one can
17 observe that hospital "prices," or charges, account for only about one-quarter of total costs
18 covered in a given area by a health insurer. This obviously limits the impact one can obtain by
19 urging restraint in hospital charges, as the Maine Legislature did in 2003.
20 The 50/50 rule of thumb also suggests that better controlling healthcare utilization should
21 be pursued as an approach to controlling total healthcare costs. This could include enhancing
22 disease prevention measures, permitting insurers greater latitude in bargaining with hospitals by
23 relaxing access rules and making healthcare more consumer-driven (unlike the current system in
24 which the insured is almost indifferent to the price of various care options and procedures).

1 **Q. Have the Maine plans themselves taken any steps to address the utilization issue?**

2 A. Yes, we have. Let me offer just one example. My company, CIGNA, has disease
3 management and wellness programs in place that not only improve the health of our subscribers,
4 but result in significant cost savings to our customers. (Attached as Tobin Exhibit 2 is a CIGNA
5 Press Release from last March describing one such program: a weight management and smoking
6 cessation program.) The business logic underlying these programs is very simple: the health
7 insurance company can lower its claims experience, and thus reduce its costs, if it succeeds in
8 improving the health of its members, in turn causing them to reduce hospital utilization. These
9 programs also allow us to compete more effectively in the marketplace.

10 **Q. Does the DHA method of determining savings undermine the incentive for such**
11 **programs?**

12 A. Very definitely. Under the DHA approach of attributing 100% of determined savings to
13 DHA, any cost savings that a plan's smoking cessation or weight management program might
14 produce will be counted as a DHA-generated cost saving, resulting in an SOP assessment from
15 DHA in a year or two. This would wipe out any gain realized by the health insurance company
16 through member wellness initiatives.

17 **Q. The CMAD measure used by DHA to calculate savings seems to equate hospital**
18 **expenses with hospital charges. Is this an appropriate assumption?**

19 No. I concur in the point made by Mr. Keane in his testimony that hospital revenues
20 have tended to accelerate faster than hospital expenses, rendering DHA's hospital-expense-based
21 CMAD calculation meaningless for the purpose of determining whether carriers have seen any
22 savings (whether generated by DHA's operations or not). As Mr. Keane states, DHA has

1 predicated its savings calculation on the assumption that hospital costs and hospital charges have
2 a one-to-one correlation. As Mr. Keane demonstrates, no such correlation exists. CIGNA,
3 Anthem and the other MEAHP members are almost universally on a percentage-of-charge basis
4 with Maine hospitals. In the absence of data demonstrating that hospitals flow through expense
5 savings by adjusting their charges accordingly, any "savings" identified through the CMAD
6 technique should be disregarded.

7 III. The "Carrier Initiative."

8 **Q. In the 2003 law, the Maine Legislature requested Maine health plans to limit their**
9 **underwriting gain to 3%. DHA has included $11.2 Million from this initiative as part of its**
10 **SOP Total. Do you agree with this?**

11 A. No, I do not for several reasons.

12 First of all, it would not be logical for the Legislature to include this within the pool of
13 savings justifying the assessment to be levied by DHA. Fundamentally, what DHA is saying
14 here is that in Year One a Maine plan set its rates to recover $11.2 Million less than it otherwise
15 would have recovered due to a supposed restraint in underwriting gain. If DHA is now allowed
16 to impose an $11.2 Million SOP assessment in Year Two, then all of the Maine plans will simply
17 have to increase premium in Year Three by $11.2 Million to recover the assessment. Each year's
18 assessment would thus wipe out, dollar-for-dollar, the previous year's "savings", meaning that
19 there would never be any real savings incurred by the Maine healthcare system from this source.

1 **Q. Could the savings from this source be passed along from the providers to the plans**
2 **in negotiations?**

3 A. No. As I understand it, these "savings" are supposed to take the form of an underwriter
4 deciding to limit its underwriting gain, and therefore charging a lower premium for its health
5 insurance product than it would otherwise charge. This is not a cost saving that a healthcare
6 provider has allegedly realized (which may or may not be passed on to us through lower
7 charges), and it therefore cannot be "wrung out" of the providers in negotiations.
8 I am also concerned that including the supposed result of underwriting gain restraint in
9 the SOP pool might encourage plans to manipulate the system, with negative consequences.

10 **Q. Could you please explain your concern in this regard?**

11 A. Yes. Keep in mind that a plan can limit its underwriting gain by a variety of means. For
12 example, assume Plan A incurs substantial costs in Year One in launching a new product or
13 service. Keeping all else equal, this would tend to depress Plan A's underwriting gain for Year
14 One. To dramatize the impact of this, let us assume that but for the cost of its new product
15 launch, Plan A's underwriting gain would have been 5%. Now let's assume that the other Maine
16 plans did not restrain their underwriting gains in Year One, but that the costs of Plan A's product
17 launch, which drove its underwriting gain from 5% to, say, 1.5%, produced Year One "savings,"
18 as determined by the DHA/Mercer approach, of $10 Million. Under DHA's methodology, we
19 exclude the data from the non-restraining plans and look only at the data from Plan A, which
20 shows a gain of less than 3% (again, due to the costs associated with its new venture). The $10
21 Million SOP assessment levied by DHA in Year Two based on Plan A's savings would fall on
22 all plans in proportion to their respective shares of paid claims in the Maine market. Thus, the
23 result in this example would be to force all of the Maine plans to subsidize a portion of Plan A's

1 product launch costs. To follow this along to its ultimate result, in Year Three, when Plan A and
2 the other Plans pass this assessment along to their members in the form of an increase in
3 insurance premium (because, as I mentioned before, there is no argument that a plan could wring
4 the savings derived from restraining underwriting gain from hospitals or other providers), the
5 members of all of Maine's health plans would end up subsidizing Plan A's product launch via
6 the SOP assessment.

7 By the way, a plan might also limit its underwriting gain (and lower its prices) simply to
8 obtain additional market share by underpricing its competitors. Under DHA's approach, the
9 resulting "savings" would be included in next year's SOP assessment, thus forcing the
10 underpricing plan's competitors (and, ultimately, their members) to shoulder a portion of the cost
11 incurred by the undercutting plan of obtaining the additional market share.

12 As this shows, DHA's attempt to levy an SOP made up, in part, of supposed savings
13 resulting from underwriting gain restraint makes no sense and in fact could encourage conduct
14 that would be very harmful to consumers.

15 IV. Negative Effect of an SOP.

16 **Q. Maine law provides that health plans will be able to pass the SOP along to their**
17 **members in the form of higher insurance rates. Since consumers will be paying for this,**
18 **why is MEAHP so concerned with the SOP level?**

19 A. As with any other product, as one increases the price of the product (for any reason,
20 including the imposition of new taxes), the market shrinks. Imposition of an SOP assessment
21 would require CIGNA and the other members of MEAHP to increase the price of our products to
22 a higher level than would have been the case in the absence of the assessment. This will
23 probably result in some further shrinkage of the private health insurance market in Maine,

1 making the "pie" smaller for all competitors in the market. Quite simply, this is bad for our
2 business and bad for Maine consumers

3 **Q. Can you quantify the number of Maine people who will lose their health insurance**
4 **as a result of an SOP assessment?**

5 A. No. However, I am generally familiar with, and consider reliable, the studies underlying
6 Anthem witness Sharon Roberts' estimate that a 1% increase in the price of health insurance
7 results in 300,000 Americans losing their coverage. I have also reviewed Mr. Shiels' testimony
8 on this subject and I consider his assessment to be reasonable.
9 Whatever the relevant factor of price versus lost coverage might be for Maine, there can
10 be no question that a number of Mainers will lose coverage if the SOP assessment is imposed.
11 Nationwide the number of uninsured continue to rise and employers continue to lower their
12 contribution amount for premium. An additional assessment increase (especially without
13 offsetting actual savings) will further exacerbate this problem.

14 V. Conclusion.

15 **Q. Do you have any concluding remarks?**

16 A. DHA's experts have admitted that DHA's savings calculation was not based on a
17 measurement of savings generated by DHA's operations. For that reason alone, I recommend
18 that the Superintendent find that DHA has not proven any "aggregate measurable savings" in this
19 case.
20 If DHA's savings calculation is approved, it will pave the way to an increase in Maine
21 health insurance rates. The resulting increase will cause some number of Maine people to lose
22 health insurance despite the fact that Mercer has admitted that its SOP calculation was not based

1 on measured savings actually generated by DHA. This cannot be the result that the Maine

2 Legislature intended when it launched DHA.

3 **Q. Does this conclude your testimony?**

4 A. Yes, it does.

TOBIN EXHIBIT 1

Figure 1. 1988–2010 Premium vs. Cost Increases — Our Modeling Assumptions

year-over-year % change

19.0%
14.0%
9.0%
4.0%
-1.0%

Physician
Hospital
Drug

Premium Yield
Medical cost growth
HSAs in Jan '04

11.7%
18.2%
17.7%
13.2%
10.4%
8.1%
6.5%
-0.4%
-0.5%
2.1%
3.2%
5.7%
9.0%
11.0%
13.5%
13.0%
11.0%
8.0%
6.0%
5.0%
4.0%
3.0%
2.0%

1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005E 2006E 2007E 2008E 2009E 2010E

Source: 1988–2004 data from CMS, Milliman USA, AAHP, KPMG; 2005–10E from Citigroup Investment Research

Tobin Exhibit 2

Press Release Source: CIGNA HealthCare

CIGNA's Healthy Rewards(R) Program Expands Weight Management and Tobacco Cessation Offerings

Thursday March 18, 9:04 am ET

New Programs Address Leading Causes of Preventable Deaths and High Medical Costs

BLOOMFIELD, Conn., March 18, 2004 /PRNewswire-FirstCall/ -- Tobacco use and obesity rank as the leading causes of preventable death in the United States, killing nearly 435,000 and 400,000 Americans respectively in 2000(1). They also contribute to higher medical costs. In fact, studies show the annual medical claims are 27 percent higher for employees who smoke and 36 percent higher for those who are obese compared to their non-smoking and non- obese counterparts(2).

To help address these concerns, CIGNA HealthCare recently expanded the weight management and tobacco cessation offerings available to members through its Healthy Rewards® health and wellness discount amenities program, where members can receive up to 60 percent off the retail price for a myriad of products and services.*

Through an agreement with Weight Watchers North America Inc., CIGNA is the first health insurance carrier to offer discounts for Weight Watchers' three different programs nationwide.

The company also signed an agreement for Tobacco Solutions, an eight-week tobacco cessation program offering deep discounts on the Novartis Habitrol Transdermal system, "the patch," and behavioral support through educational materials and toll-free counseling support five days a week.

Through another arrangement, CIGNA members can receive a discounted lifetime subscription rate to QuitNet®, an online smoking cessation program and community available 24 hours a day with access to support, counseling and education to help them quit smoking and remain tobacco-free.

"CIGNA Healthy Rewards® works hand in glove with employers' corporate preventive health and wellness programs," said Diana Wynne, project manager for CIGNA's Healthy Rewards® program. "More and more, employers recognize that investing in promoting wellness can reap big returns. Through Healthy Rewards®, the employer can save and so can the employee."

In fact, some large U.S. corporations have estimated an average return of $5 for every dollar invested in wellness programs and an average 2.5 percent drop in healthcare costs(3).

Healthy Rewards® offers discounts on a variety of programs that emphasize weight management, nutrition, fitness and healthy lifestyle choices, as well as savings on other products and services consumers use every day.

From Jan. 1, 2001 to June 30, 2003, more than 50,000 CIGNA members have saved $5.6 million through Healthy Rewards® on fitness club memberships, herbal and nutrition supplements, over-the-counter health and beauty products, vision and hearing care services, and laser vision care.

Wynne said the actual savings and member participation in Healthy Rewards® are even higher than these statistics suggest. "One consumer benefit of the program is that there is no paperwork or referral. So, data on some of the offerings like discounts on massage therapy, chiropractic care, acupuncture and cosmetic dentistry are more difficult to track."

Through the latest Healthy Rewards® offerings, CIGNA members can receive the following savings:

-- Weight Watchers(R) Traditional Meetings - Free registration at group meetings. A $15-28 savings depending on location.*

-- Weight Watchers Online - $10 discount on the 3-month subscription for online access to personalized weight management tools, information and resources. The retail price is $59.95 and is available to CIGNA members for $49.95.

-- Weight Watchers At Home - $10 off the retail price ($99.95 plus shipping and handling) of at-home kit in participating areas. Members pay $89.95 plus shipping and handling.

-- Tobacco Solutions - Over 50 percent off the $281 retail price. CIGNA members pay $135, which includes eight weeks of the Habitrol patch. At $4 for a pack of cigarettes, that's less than half the cost the average pack-a-day smoker would spend over the same period.

-- QuitNet(R) - Members receive a special lifetime subscription rate of $65, a 35 percent discount off the annual membership price of $99.