

Health Insurance Advisory Council
October 17, 2006
5 – 6:30 PM – DBR Hearing Room

Minutes

Attendance:

Members: Annemarie Monks, Dawn Wardyga, Ed Quinlan, Bill Martin
Elizabeth Walsh, Hub Brennan, Howard Dulude, Peter
Quattromanni, Craig O’Connor, Rick Brooks and Chris Koller
(Co-Chairs)

Health Plans: Tom Boyd, Jason Martesian, Ken Pariseau

OHIC Staff: John Cogan, Matthew Stark, Patricia Huschle, Adrienne Evans

Excused: Serena Sposato

Absent: Patrick Quinn, Ann Rhodes, Denise Lynn, Josh Miller, Domenic
Delmonico

1. Introductions
 - Members of the Council introduced themselves.
2. Updates
 - September 19, Minutes
 - Approved with no changes.
 - Membership:
 - Business representatives are being solicited in particular, as the Council is underrepresented here. Council members were asked to pass on names to Mr. Brooks or Mr. Koller
3. Co-Chairmanship
 - Statute calls for Council co-chair from Consumer or small business organization.
 - Rick Brooks was nominated to serve a one-year term as co-chair.
 - He was elected unanimously. Members asked that appreciation for his service be noted.
 - It was the wish of the council that a co-chair be elected for a two-year term starting next September.
4. Issue: Rate Review Process for Insurers.

The issue for the council tonight was to explain what authority the commissioner has over the rates insurer sets, and to get feedback from the Council about a proposed process for using that authority.

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John Cogan and Chris Koller reviewed a table for the council (attached) that explained how the rate determination process differs for each line of business in the Rhode Island Health Insurance Market. In general authority ranges from none (for self insured products) to approval of rating manuals (for large groups) to legislatively prescribed rating factors (groups of size 1-50) to optional or required rate hearings (Medigap and Direct Pay). The more vulnerable the group covered, the more legislation tends towards strict rate setting. Rate hearings result in ruling by the Commissioner which can accept, reject or amend rates and attach conditions. Commissioners' decisions are appealable in court.

BCBSRI has been, historically more subject to rate scrutiny than its peers.

Discussion turned to the role of the rate setting process in making assessments of products – particularly consumer directed health plans and their effects on providers. In general, the conditions attached to rate hearings do not extend to how a product is administered. Such policies are made either through legislation or regulation, rather than rate hearings.

Discussion then centered on the rate hearing process. It is governed by the administrative procedures act and tries to replicate a trial process in an administrative setting. The filer and the Attorney General are parties in the hearing and the hearing officer presides. There is discovery, evidence, expert testimony and public comment. The hearing process allows for public accountability and due process, but is long and expensive; the last Direct Pay Hearing consumed 5 months and \$900,000 in fees to consultants and lawyers – or almost 15% of the cost of the direct pay product. BCBSRI generates most of the costs, followed by the AG and then OHIC. There is also no ability to negotiate with the filer once the filing is made.

OHIC is developing a process for the current BCBSRI Medigap filing which would try to replicate the evidentiary and accountability aspects of a formal public hearing without the expense and time.

- AG would participate.
- Evidence presented and collected.
- More direct contact between OHIC, the AG and the party during the process.
- Two public meetings to collect testimony.
- All commemorated in policy, regulation and – as needed – statute.
- Appeal rights for the AG if not satisfied

The Council was asked to provide feedback on this process.

- Strong need for public testimony and input.
- Lack of understanding or appreciation for the expense of lawyers, actuaries and other consultants – amounts to a user fee, since it is all paid by the filer (who passes it on in premiums).
- Mixed opinions on whether the AG role is needed to protect public interest. Some felt that the OHIC needed some one dedicated to public interest, others

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- felt that was OHIC role and it needed a watchdog, then shouldn't the watchdog have a watchdog?
- Was there any ability to cap the amount of fees spent in the process? Do consumers have to pay this cost? (ultimately, yes)

The Council asked for an assessment of the Medigap process once it was completed but was supportive of the general direction, provided safeguards were put in place for public accountability and administrative consistency. Staff will provide that assessment once the Medigap process is complete – early in the New Year.

Council also commented on the variation of oversight of BCBSRI and other insurers – why shouldn't they get scrutiny, and the lack of oversight in the small group and large group markets.

¹The following article, **Understanding How Health Insurance Premiums Are Regulated** was not discussed at the meeting but will lend further insight to the discussion. This article can be obtained through the following footnoted link.

Next Meeting:

November 21, 2006

5 pm. DBR Hearing Room.

Topic – what price and quality info should health insurers disclose to people with high deductible health plans?

¹ <http://www.familiesusa.org/issues/private-insurance/rate-regulation-6-what.html>