

**Health Insurance Advisory Council  
December 18, 2007  
5 – 6:30 PM – DBR Hearing Room**

**Minutes**

**Attendance:**

Members: Serena Sposato, MD, Phil Papoojian, Bill Martin, Howard Dulude, Denise Lynn, Rick Brooks and Chris Koller (Co-Chairs)

Health Plans: Tom Boyd, Stephan Katinas, Ken Pariseau, Neil Galinko, MD, Mack Johnston, MD, Jason Martiesian, Nancy Coburn, Michelle Lederberg

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

Not in Attendance: Bill Schmiedeknecht, Patrick Quinn, Dawn Wardyga, Domenic Delmonico, Hub Brennan, DO, Peter Quattromani, Ed Quinlan, Elizabeth Walsh, Roland Benjamin

1. Introductions
  - Members of the Council introduced themselves.
2. Review of Minutes
  - November 2007, Minutes
    - Minutes for the November 20, 2007 meeting were reviewed. There were no changes to the notes.
3. Updates
  - BCBSRI settlement with US Attorney:
    - Chris Koller briefly reviewed OHIC's involvement with the recently announced agreement between BCBSRI and the US Attorney. OHIC was consulted by the US Attorney around certain facts regarding BCBSRI's operations and finances prior to the negotiation of the agreement. It had no role in the negotiation.
    - Rick Brooks asked about the payment of a \$20 million fine and what its effect would be on BCBSRI reserves and future rate increases. Mr. Koller said that \$20 million would not have a significant effect on the solvency of the plan. It does however place BCBSRI reserves further from the target levels recommended to HIAC in 2005 – and year end operating surpluses go into that general reserve fund. Tom Boyd noted that BCBSRI has pledged that it will not seek rate increases specifically designated to account for this payment.
4. Discussion: Role of OHIC with regard to Health Plan Provide Reimbursement Strategies.
  - Chris Koller started off this discussion by noting that OHIC has a statutory obligation to direct health insurers in Rhode Island towards policies that

## Health Insurance Advisory Council

### Minutes

December 18, 2007

promote improved health care access, efficiency and quality. One of the most significant policies that health plans implement is how they pay providers. Methods of payment can encourage and discourage certain provider behaviors. Nationally, state regulation has ranged from rate setting at one extreme to hands off at the other. Given the statutory mandate of this Office, Mr. Koller is looking for recommendations from the Council on the role of the Office in these health plan policies. For background, he referred Council Members memorandum he wrote to the RI health plans as preparation for this session and the specific request of the health plans to speak to four areas regarding their hospital and primary care payment methodologies:

1. What is the dominant methodology and how was that arrived at?
2. Current incentive mechanisms and future plans.
3. Barriers to implementing those changes
4. Merits of consistency of incentives across payers.

Mr.Koller confirmed that no payment levels were to be discussed tonight and no topics should be construed as being anti competitive or restraining of trade.

- Dr. David Gifford, Director of Rhode Island's Health Department, introduced Council members to the topic. He spoke to the overwhelming influence of behavioral factors (diet, exercise, tobacco use and environment) on individual health, compared to medical care. In the realm of the medical care, however, the value of that care (i.e. quality and efficiency) is significant influenced by methods of payment.
- For primary care physicians, these reimbursement methods include fee for service, capitation and incentives. (in response to a question, he also noted salaries.) Each of these produce different incentives – fee for service is good for creating physician access and rewards procedures , but discourages preventive health, collaboration or patient education (Dr. Sposato concurred).
- For hospitals, these include percent of charges, per diems and case rates – with quality incentives. Medicare is the dominant payer and drives much practice. Medicare has made a few steps towards paying for hospital quality but not major ones, because measurement is difficult. In terms of incentives, Dr, Gifford cited efforts to pay for the things that lead to quality, if outcomes are hard to measure – the best local examples of this, he said, are BCBSRI's efforts to promote Electronic Medical Record Adoption.

### Plan Presentations and Discussion

(See attached summary)

Health Insurance Advisory Council

Minutes

December 18, 2007

The Council agreed to continue this topic at its January Meeting. There was much interest in how to increase collaboration and consistency among the plans to reduce some of the perverse incentives that currently exists. The issue becomes more topic for hospitals, given the proposed Lifespan/Care New England merger. As with the HIT topic previously addressed by the Council, there are a variety of regulatory positions which could be adopted by the Office.

There was no further discussion.

Next Meeting of the Council

January 15, 2008

5 pm DBR Main Hearing Room

**Summary of Plan Presentations on Payment Strategies:**

	<b>United</b>	<b>NHPRI</b>	<b>BCBSRI</b>
<b>Question 1: Dominant Payment Methodology</b>			
<b>Primary Care</b>	Fee for service off Medicare	Primary Care Capitation to larger sites. Fee for service to rest.	Fee for Service off of Medicare. Don't envision getting off this – perhaps more incentives.
<b>Inpatient</b>	Per diems at majority of hospitals, case rates at others. (case rates preferred)	Mostly per diems. Some case rates – would like to do more.	Per diems dominate (want to more case rates.)
<b>Question 2: Current and future incentive programs.</b>	<p>Practice Reward program – pays supplemental fee for service amount (5%) to physicians meeting quality and efficiency standards. Standards are set and measured nationally          Trying to pilot patient centered medical home nationally and locally. (CSI initiative out of OHIC)</p> <p>Hospitals – nothing.</p>	<p>Primary care – pay extra for access, clinical quality and patient satisfaction performance..</p> <p>Would like to pay more for patient centered medical home - especially for high needs members. (CSI initiative out of OHIC)</p> <p>Hospitals – not much.</p>	<p>PCPs:          -Rate increase linked to EMR take up. (3 year program – ends up at 15% differential if EMR is adopted.)          -“Quality Counts” program – provides incentives to adopt and report clinical measures from EMR.          -Some pay for performance for large groups based on individual contracts. .          -Medical Home pilot (CSI initiative out of OHIC)</p> <p>Hospitals:          Hospitals - Some “never event” discussion and starting pay for performance - following Medicare example.</p>
<b>Barriers to implementing these incentive programs</b>	<p>-Provider distrust and resistance to being measured.          -Source of Measures (claims – are they reliable?).          -Hospital resistance and negotiating</p>	<p>-Limited leverage with hospitals.          -Overall Rite Care capitation is not large. Limits ability to invest. .          -Federal Regulation (EMTALA) for ER</p>	<p>-Provider distrust and resistance to being measured.          -Sources of Measures.          -Competitive disadvantage if other plans free load.          Hospitals – resistance and</p>

Health Insurance Advisory Council  
 Minutes  
 December 18, 2007

	<b>United</b>	<b>NHPRI</b>	<b>BCBSRI</b>
	leverage. -Nationally driven strategies.	services – seen as limiting ability to focus on ERs.	negotiating leverage (just won't do it).
<b>Comments on standardization</b>	(none)	Pro: evens playing field and helps small providers. Cons-limits innovation. Does not get at basic delivery system issues.	Pros: improvements in outcomes more likely, admin efficiencies. Cons: consensus building. Picking priorities means important issues not rewarded.
<b>Council Discussion</b>	Mr. Martiesian apologized for the lack of detail and offered to give a more detailed presentation next time. (United's "Q&E" measurement program has been discussed by Council before) Dr. Sposato stated that if she were paid for counseling people she would do more of it. Some discussion of regional parity with Mass – how important is this?	Could you put more dollars into quality? Especially in primary care? Note historical commitment to Community Health Centers means most of effort is there. What sorts of behaviors does capitation create?	Standardizing EMR – hard or easy? Who pays?  Hospital resistance to quality measures – why? Just because they are big? BCBSRI says their market share makes it hard to change payments since dollar swing is big for providers. -Hard to measure outcomes. – we settle for “we did not operate on the wrong part”. Council members said “this is crazy!” -Providers don't like different quality and incentive programs among plans – distracts them and lessens impact.