Health Insurance Advisory Council
February 19, 2008
5 – 6:30 PM – DBR Hearing Room

Minutes

Attendance:

Members: Domenic Delmonico, Phil Papoojian, Denise Lynn, Roland Benjamin, Hub Brennan, DO, Bill Martin, Peter Quattromani, Ed Quinlan, Chris Koller (Co-Chair), Rick Brooks (C0-Chair)

Health Plans: Ken Pariseau, Tom Boyd.

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

Not in Attendance: Bill Schmiedeknecht, Patrick Quinn, Ed Quinlan, Elizabeth Walsh, Serena Sposato, MD, Howard Dulude, Dawn Wardyga,

Guests: Josh Miller, Jennifer Wood

1. Introductions
   - Members of the Council introduced themselves. Sen. Miller was welcomed back a member emeritus.

2. Review of Minutes
   - January 2008, Minutes
     - Minutes for the January meeting were reviewed. There were no changes to the notes.

3. Updates
   - Direct Pay Filing:
     - Chris Koller reviewed with the Council OHIC's order on the recent Direct Pay filing. OHIC reduce pool 1and pool 2 requested rate increases from 15 and 8% to 11 and 4. OHIC cited the following factors
       - No contribution to reserves (1.25%)
       - No allocation of costs of Prospoed Wellness Health Benefit Plan to other subscribers (.4%)
       - Recalculation of administrative cost savings (.4%)
       - Sharing of IT system costs (.15%)
       - Weaknesses in affordability plan (1.0%)
       - Weaknesses in inpatient utilization management (.8%)
     - In response to a questions Mr. Koller cited that the projected medical benefits ratio for the filing as in the low to mid 90s – lower for high deductible plans and higher for low cost sharing plans. The order indicated that BCBSRI's efforts to manage the costs of their products could be stronger.

- Golden Rule
    - In response to a question. John Cogan said that Golden Rule continue to express an interest in participating in the individual market and has requested a meeting to discuss the status of their application. OHIC will continue to be guided by the principles discussed in the HIAC for a new entrant into the Direct Pay market – that there not be two standards of performance or underwriting.

4. Discussion: Report of Market Merger Task Force

Mr. Koller introduced this section of the meeting. Last spring the legislature asked for the formation of a study group of businesses, direct pay consumers, brokers and health plans to consider merging the small group and individual markets, as was done as part of the Massachusetts health reforms. The Task Force, which included Josh Miller and Phil Papoojian, has completed its work. The purpose of this meeting was review its findings.

To start, Mr. Koller reviewed how small group insurance is rated in RI (adjusted community rating based on a limited number of rating factors). The intent is to have consistent rating rules that apply to every one. This does not allow for group purchasing – although some groups of businesses think this would be a good deal, studies show that it has little effect on the price of health insurance in the long run, unless the purchasing pool is mandatory. Several questions were asked about MEWA's –Multiple Employer Welfare Arrangements – these are groups of business who form a group to self insure for medical or other expenses. They are illegal in RI because they are susceptible to abuse and fraud.

Mr. Koller presented a summary of the Task Force's Work:

As directed by the Legislature in 2007, the market merger task force considered five main areas of analysis and discussion during September through December 2007:

(1) Assessed the stability of the individual market;
(2) Assessed the effect of merging the individual and small group markets;
(3) Evaluated various changes to rating rules in order to stabilize the small group market;
(4) Measured the effects of an individual mandate to purchase health insurance; and
(5) Discussed the current distribution channels, product simplification and regulatory authority.

In considering the five key topics above, the task force was concerned that the project should not simply "rearrange the deck chairs on the Titanic"; that is, they wanted to be sure the project addressed systemic issues related to health care costs and access that might otherwise be considered outside the scope of the project. As such, the task force developed a "longer-term direction" to guide decision-making related to the more narrow context of this study. This longer-term direction included four key elements:

(1) Community rating: defined here as consistently applied rating rules;

(2) Everyone in the pool: health insurance for all Rhode Islanders;

(3) Subsidies for those who can not afford coverage; and

(4) Regulation of products and rates.

Given this long term direction., the following short-term recommendations were generally accepted by the task force, with a few key exceptions and caveats:

- Merger
  Do not pursue merger of individual and small group
  Do not pursue expansion of small group to include companies with up to 100 employees
- Community Rating
  Eliminate the use of health status as a rating factor
  Add a group size factor of at least 5% for groups of one
  Retain 4:1 compression
- Everyone in the pool
  Individual mandate over 400% FPL
- Subsidies
  None (at this time) due to state budget status
- Regulation
  Move groups of one to individual market (*subsequently not pursued)*
  Eliminate broker volume and persistency bonuses

The Group discussed the short term recommendations in general. Sen. Miller and Mr. Papoojian both spoke to the engaged participation of the task force members, and the difficulty of developing consensus on what specific reforms were appropriate. The short-term recommendations will not drastically change the environment – and some task force members believe that drastic change is needed.

The group briefly discussed the recommendation for an individual mandate for families with incomes of 400% or more of poverty level. In the absence of the money and momentum for comprehensive reform the task force felt this was a good first step at enforcing a sense of mutual responsibility.

There was discussion about the structure of the Direct Pay market (highly regulated, limited product offerings) and the Small Group Market. In the long term, how do these look more like one another, especially since the task force analysis indicates that Direct Pay marketing/distribution is simpler and the pricing is cheaper (although some of this could be a cost shift to other markets, not real efficiencies)?

Part of the answer may lie in the "connector" model that was part of the Massachusetts Reform model. The Mass Connector is a state authority which "connects" purchasers to health insurance products by structuring the market:

- defining product levels and criteria,
- conducting an rfp process with plans
- putting in place a structure for the purchase (and subsidization) of health insurance products by individuals and groups.

Mr. Koller directed Council members to the connector web site, which tries (and in his opinion largely succeeds) in making the purchase more like an on-line shopping experience ("The Travelocity of health insurance" is how they describe it).

This type of structure also facilitates more individual purchase of health insurance if the market is moving in that direction. Could it be applied to Rhode Island?

- market is much smaller – may not need all the infrastructure
- because of market size, probably would have to run everybody through it, rather than put it along side the existing purchasing system. That is a big change.
- OHIC has more rating authority than existed in Mass, but not product authority.

At this point Jennifer Wood, of the Lt Governor's office reviewed the Lt Governor's health care package, which expands upon ideas in the market merger task force. The package falls into three components:

- Efforts to reduce cost and improve quality
- Restructuring the Individual Market with a "health hub" based on the Massachusetts Connector.
- Beginning efforts at financing with the Individual Mandate as discussed above and a requirement that employers with ten or more employees provide health insurance or pay a fine.

Discussion centered on the third item and benefits/drawbacks of the mandates. There are workers who make less than 400% of FPL and are unwilling to buy their employer's health insurance. There are employers who pay their employees not to buy health insurance. More generally – if the employer-financed health care model is fragmented and uneven, should policy be directed to more public financing of health care or more individual financing? Which would be more effective at getting at the underlying drivers of medical costs? In the absence of consensus, the steps talked about here try to get more people "into the pool" and make the current insurance market work better

Mr. Koller thanked the Council for the discussion, which will help guide future efforts by the Office.

Next Meeting of the Council
March18, 2008
5 pm DBR Main Hearing Room
Topic – Revised rate filing process for commercial insurers