

**Health Insurance Advisory Council**  
**March 18, 2008**  
**5 – 6:30 PM – DBR Hearing Room**

**Minutes**

**Attendance:**

Members: Domenic Delmonico, Phil Papoojian, Roland Benjamin, Bill Martin, Bill Schmiedeknecht, Howard Dulude, Chris Koller (Co-Chair), Rick Brooks (Co-Chair)

Health Plans: Ken Pariseau, Jim Joy.

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

Not in Attendance: Patrick Quinn, Ed Quinlan, Elizabeth Walsh, Serena Sposato, MD, Dawn Wardyga, Denise Lynn, Hub Brennan, DO, Peter Quattromani,

1. Introductions
  - Members of the Council introduced themselves.
2. Review of Minutes
  - February 2008, Minutes
    - Minutes for the February meeting were reviewed. There were no changes to the notes.
3. Updates
  - There were no updates for the Council.
4. Discussion Topic – Feedback on Proposed Standards to be used by OHIC in reviewing rate factor submissions from health plans.

**Background**

Chris Koller distributed a briefing paper for the Council, which gave background on the Revised Trend Review Process and the Components of the Process. The purpose of the meeting is to solicit feedback from the Council on the Standards OHIC will use for its review.

A copy of the briefing paper is attached.

The goals of the trend review process are:

1. Consistency of reviews of rating components among plans and across markets.
2. Annual Cycle
3. More Public Accountability, Transparency and Comparability
4. Public Education

5. Better basis for holding health insurers accountable for affordability efforts.

Regarding the statutory guidance for the Office's work, Domenic Delmonico asked if there were standards for "fair treatment of providers", including the solvency of providers. Chris Koller said there were none.

Mr. Koller reviewed the process (see background document) for review, noting that large group trends would be reviewed separately from small group trends this year. This will be the first year for the process and it is anticipated that there is much to learn - regulations would be developed after the review, based on the experience.

He also noted that trend factors are the inputs for determining the rates for every employer, along with employer-specific characteristics. The plans use rating formulae described in their rating manual and are supposed to apply them consistently.

OHIC has the authority to approve, modify or reject the proposed trend factors. The importance of this discussion is that OHIC needs clear standards for review of each trend factor component. These standards will be used to balance competing needs – such as adequate reserves, adequate provider rates and affordable health insurance premiums.

The conversation then turned to the rate factors which OHIC will be reviewing, and clarifying Council questions about them:

- In every case, the Office is using percent figures for comparison rather than absolute numbers. Comparability is becomes very difficult with absolute numbers because of accounting and population differences.
- Contributions to reserves: (as percent). This is self-explanatory.
- Administrative Costs. There was considerable discussion on whether the inverse (Medical Benefits Ratio – the percent of revenue spent on medical benefits) was a more useful focus. It is hard to determine what is optimal – does a relatively low medical benefits ratio indicate favorable selection, aggressive health plan management or low provider rates?
- Trend factors (year to year % change in price and utilization for four medical service categories.) Discussion focused on the definition of medical service categories.

OHIC will be disclosing as much of the filings as is permissible by law. Although the information can be confusing and analysis must be done with caution, there is a public benefit to having information available for scrutiny. It also helps the Office assess what constitutes "fair treatment of providers". This must be balanced against provider concerns about what is proprietary and the possible inflationary effects of price disclosure.

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The remainder of the conversation was on the proposed standards to be used for rate factor review. Mr. Koller notes that because this is the first time OHIC has implemented this type of review, it wanted to be true to its statutory direction, but acknowledge the need to develop standards over time. As such, Council input on the standards for review was very important. A summary follows.

<b>Rating Component</b>	<b>Factors to Consider</b>	<b>Council Comments</b>
Contributions to Reserves (Percentage)	Existing Reserve relative to OHIC reserve levels Industry Averages Historical factors/changes in surplus Return to shareholders (if appropriate) General Conduct (defined in Reg 2)	Can you require a company to take a loss? Helps to have the SAPOR standards in place. How to take into account (un)profitability of other lines of business?
Administrative Costs (as % of total revenue)	Other health plans for comparable products. Other commercial products from same insurer Compliance with NAIC categorization Affordability Efforts (defined in Reg 2) General Conduct (defined in Reg 2)	Why not take into account plan size – shouldn't admin % go down as size increases? Do high admin costs reflect increase spending on medical management and wellness? General Conduct – unrealized opportunity for health plan investments to simplify administrative systems. Supportive of standards for general conduct and affordability efforts. To assess them – health plans should have to make their case for their efforts in filings. If they don't, there should be consequences.
Trend factors (% annual projected change in utilization and costs for four service categories)	Actuarial soundness Other health plans in market Commercial industry standards Governmental Health Care Programs Affordability Efforts (as defined in Reg 2)	Little support for holding commercial health plans accountable for overall financial health of providers. Some support for pressing these factors down – otherwise, insurers seen as just passing costs on to employers. Accept the fact that market does not work and

Rating Component	Factors to Consider	Council Comments
	Relative financial health of providers in that service category.	<p>regulation/oversight is needed. How do we account for uncertainty and incentive of insurers to be cautious in predictions – so results come out better? Also – the further in advance the rate factors are filed, the more uncertainty exists in the estimates.</p> <p>To what extent are the trends the trends and this is not about managing them, just predicting them well?</p>

Based on these comments:

- OHIC will consider Medical Loss Ratio of plans as performance measure, but not as rate factor category.
- OHIC will drop the “relative health of providers in that service category” standard. There still remain obligations to “for fair treatment of providers” by plans.
- OHIC will not interpret these standards strictly, but use them as guidance.
- OHIC will disclose as much of the filing as is allowed statutorily.

Mr. Koller thanked the Council for its work. The Office is attempting to construct credible processes for carrying out its statutory direction to balance the needs of health insurance consumers and purchasers, medical care providers and the medical care system in RI. Rate factor oversight is a critical component where these needs can conflict with one another. The Council’s input is important to the Office’s work.

Next Meeting of the Council

April 22, 2008 (**note new date – one week later**)

5 pm DBR Main Hearing Room

Topic – Review of submissions for large group rate factors.