

Health Insurance Advisory Council
December 16, 2008
4:30-6:00 PM – DLT Main Conference Room

Minutes

Attendance:

Members: Serena Sposato MD, Rick Brooks (Co-Chair), Peter Quattromani, Hub Brennan, DO, Chris Koller (Co-Chair), Ed Quinlan, Phil Papoojian, Howard Dulude, Roland Benjamin, Karen Fifer Ferry, Pat Mattingly, Peter Asen

Health Plans: Jason Martiesian, Lauren Conway, John Lynch

OHIC Staff: Deb Faulkner, Angela Sherwin, John Cogan, Adrienne Evans, Michael Bailit (consultant)

Not in Attendance: Bill Martin, Bill Schmiedeknecht, Denise Lynn, Elizabeth Walsh, Ted Almon, Domenic Delmonico,

1. Introductions

- Members of the Council introduced themselves. Chris and Rick introduced new member Peter Asen, a staff person for the Health Care Organizing Project and consumer organization representative to the Council, as noted in its Statute. Chris introduced Michael Bailit, of Bailit Health Purchasing, who is a consultant to this project. Mr. Bailit has worked primarily with states on their health care purchasing and regulatory strategies.

2. Minutes

- Minutes from the November 18th 2008 meeting were reviewed and approved with no changes.

3. Updates

- United Healthcare had submitted written comments to OHIC regarding the medical cost improvement initiatives work being undertaken by the Council. Chris shared with the Council the response of the Co-Chairs and will forward the original letter from United to the Council for their review.

4. Discussion/Feedback

Work continued on the Council's major fall item – *refining medical cost improvement priorities in Rhode Island for health plans as a condition of approval of medical cost rate factors in large and small group rate filings.*

Rick thanked the group for their engagement in this issue and complemented the staff of OHIC on their work in organizing the concept for review by the Council. He then turned the discussion over to Deb Faulkner, who reviewed a presentation for the Council.

In response to the direction of the council at the November Meeting, staff took the 21 potential initiatives and attempted to identify where there was documented research that this intervention, undertaken by a health plan or payer, produced demonstrable system savings. Deb thanked Angela Sherwin for her considerable effort in this work.

The initiatives were then organized in one of the three long term affordability strategies: a focus on delivery system change through payment reform starting with primary care; a focus on changing consumer behavior, and a focus on using health payments to build the delivery system infrastructure – primarily in Health Information Technology . The initiatives which had been demonstrated to be effective were then offered to the Council for its consideration grouped under each of the three strategies.

Deb noted that it was important for the Council to understand that the focus of accountability here was the health plan; initiatives which could ultimately be more effective at producing a more affordable health system may not have made the cut because the responsibility for implementing them could not be attributed to the health plan, which will be held accountable for this work as a condition of rate factor approval.

After reviewing the structure, Deb went through the specific initiatives being recommended for the Council's consideration:

- I. Delivery System Change through payment reform
 - a. Health plans responsible for spending a fixed portion of their budget on primary care services.
 - b. Health plans to support payment reform to primary care physicians that promotes a chronic-care style medical home.
 - c. Health plans to participate in collaborative efforts at more broad-reaching payment reform, involving institutional providers.
- II. Consumer behavior change.
 - a. Health plans responsible for reduction in ambulatory care sensitive emergency room visits.
 - b. Health plans responsible for percent of budget spent on smoking cessation intervention.
 - c. Health plans responsible for participating in collaboratives to implement evidence-based benefit coverage,
- III. Medical Care Infrastructure
 - a. Health plans responsible for e-prescribing incentives of certain scale.
 - b. Health plans responsible for electronic health record of certain scale.
 - c. Health plans responsible for support of state wide health information exchange.

Deb then reviewed the 12 initiatives previously developed by the Council which were not recommended for further consideration and the reasons why – primarily because of a lack of evidence to support it.

The group spent the remainder of the meeting discussing the three potential strategies and the initiatives for reach.

- There was general agreement that the strategies were helpful.

Delivery System:

- Is there evidence that more dollars to primary care will result in more primary care doctors (the goal of the effort)? Not completely. Necessary bit not sufficient.
- Will increased primary care be added on to rates, or will there be a shift in provider rates? (OHIC can cap overall rate increases; plus it will be easier for health plans to hit a percentage target if they are shifting spending, not merely adding it. In practical purposes, we are talking about a rebalancing)
- Is RI its own market for provider services?
- What is meant by a chronic care model medical home (one that improves capacity to manage chronic conditions – this is the only medical home effort that actually saves costs).
- Payment changes for primary care is important – more money into fee for service will not work.
- What does payment reform to institutions look like? How would you get it done, since change is so hard? (Requires more than just plans – look at Minnesota and CA – led by legislation to set up collaboratives)

Consumer Behavior:

- Apart from smoking, no evidence that health plans can promote public health/prevention behaviors.
- No evidence that smart benefit designs work, plus it is a strong market-shaping role.
- ER reduction is both a consumer issue and a provider/primary care issue.
- Should we have plans promote or encourage HSAs and Consumer Directed Health Care? Not sure what this would look like – the market has the choice. Not clear that HSAs reduce the overall trend.
- This is frustrating because we have to change consumer behavior to change trends...yes but is that the role of the plans? Should public policy change that with underwriting factors for smoking and obesity, or no employer based health insurance?

Infrastructure:

- Note the work of plans in this already. BCBSRIU has EMR incentive and United is coming on line. RI Quality Institute is pushing the Health Information Exchange.
- Need to think about how to promote adoption, not just purchase.

Chris noted that the Medical Directors of the commercial Health Plans generally thought that option number one would be the most productive. They agree they would like to see more accountability for ER utilization among primary care providers, and for helping primary care MDS get and use Electronic Health Records.

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It as noted that anything that smacked of increased spending by the health plans would have to be justified by a return; it would be important and easier if OHIC could ascertain that no additional dollars were being spent – this would mean a rate shift among provider groups.

Chris noted this is a tension – parties who are looking for an investment return are frustrated with health care. Whether it is HIT or primary care, it is very hard to attach specific returns.

When polled, based on the studies presented the Council expressed general support for a modified version of strategy one, with inclusion of EMR incentives for primary care, and an outcome measure for the payment reform initiative of reduced ER utilization.

Concerns with this approach centered on three issues:

- Was the council ignoring the need to change consumer behavior?
- The benefits of administrative simplification are real and should be considered
- There should be no inflationary effect of strategy one – even in short term.

The staff will take the Council's recommendation and develop specific standards for the January 20, 2009 meeting. These will be previewed with the Health Plans prior to then and distributed to the Council for review. Staff will also start work on the discussion of standards for administrative and reserves/profit ratios, which comes next.

The meeting then adjourned.

Next Meeting of the Council
January 20, 2009

4:30 pm DLT Main Hearing Room (note new Time)

Topics

- Initial Recommendations for Plan Affordability Standards, based on Council recommendations.
- First discussion on standards for administrative and reserve/profit ratios.