

Health Insurance Advisory Council
February 17, 2009
4:30-6:00 PM – DLT Main Conference Room

Minutes

Attendance:

Members: Rick Brooks (Co-Chair), Hub Brennan, DO, Chris Koller (Co-Chair), , Howard Dulude, Roland Benjamin, , Domenic Delmonico Bill Martin, Bill Schmiedeknecht , Pat Mattingly, Peter Asen, Serena Sposato MD, Peter Quattromani, Ed Quinlan

Health Plans: B.J. Perry, Tom Boyd, David Burnett, Maria LaFerriere, Gus Manocchia, Ed Hanley

Guest: Ted Almon

OHIC Staff: Angela Sherwin, John Cogan, Michael Bailit (consultant), Afrienne Evans, Sarah Mosca (intern)

Not in Attendance: Karen Fifer Ferry, Phil Papoojian,

1. Introductions

- Members of the Council introduced themselves.

2. Minutes

- Minutes from the January 20, 2009 meeting were reviewed and approved with no changes.

3. Updates

- Hearing on Direct Pay filings made by BCBSRI has been completed. A decision from Office is imminent.
- The legislation enabling high deductible health plans in RI is expiring this summer and legislative action will be needed. OHIC is statutorily required to complete a report. Given resource constraints this has not been a priority. OHIC will complete the report for the legislature using intern staff but not conduct a major review.
- There has been considerably more focus on the federal COBRA laws, which permit laid off people to continue their employer-based health insurance if they pay full premium, in light of the economic downturn. OHIC has updated its web site to give more information. The federal stimulus package will provide subsidies for people to purchase COBRA. In addition. Medicaid and Direct Pay may be more affordable options.

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.*

Michael Bailit led the group through the "Proposed Rate Factor Standards for Medical Cost Improvement" (February 16, 2009 draft) document. Six questions were posed for the Council:

- **Should modifications be made to the spend rate measure?**
- **What should five-year goal for primary care spend rate be?**
- **Year-to-year standards for health plans: absolute goals or relative improvement?**
- **Medical Home and EMR standards: should the Council be more specific about alternatives to fee-schedule increases?**
- **Proposed impact assessment**
- **Evaluation template – consequences for not meeting standards?**

These minutes will follow this format.

A. Should modifications be made to the spend rate measure?

United and BCBSRI both expressed concern about ability to collect RX expenses in the denominator; for United it is administratively difficult and Blue Cross predicts more fully insured clients carving RX out in the future (these expenditures would be unavailable to plan).

After discussion the Council agreed it would be better to include RX if possible, to allow for more comparability with national measures.

BCBSRI raised concerns about whether the payment amount studied (in both numerator and denominator) should be "net" or "allowed". Net takes into account patient cost sharing, while allowed would be the reflection of what the carrier would have paid off of fee schedules prior to any cost sharing.

Those on the council who had an opinion felt that it should be net, to reflect what the provider is actually receiving from the plan. It is not known how national measures take into account cost sharing.

B. What should five-year goal for primary care spend rate be?

This question is hard to answer because the baseline for plans has not yet been established. Pay Mattingly framed the question in terms of the goal of the process: is it to make sure the health plans are giving primary care its due, relative to other health plans with "best practices" affordability efforts, or is it to have the health plans be catalysts for a changed and re-balanced RI health system? That latter is a much broader goal.

Hub Brennan spoke to the need for regional parity in primary care payments to stabilize current conditions as a first goal but said he did not think that should be a final goal.

In response to a question it was clarified that these spend rates would be for fully insured commercial populations only. However, any changes in payment would ripple out – and almost certainly be reflected in how the plans pay for self-insured members, and possibly for Rite Care and Medicare Advantage members as well.

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Gus Manocchia pointed out that the more aggressive the goal, the greater the effects on the rest of the delivery system and the more potential "losers" would push back – with public and political efforts, more aggressive negotiating, or generating utilization. He asked if the Council and the Commissioner were willing to be held accountable when these efforts occurred.

Pat Mattingly agreed that response of other providers could be aggressive if there was to be no overall effect on premiums paid by employers. Ed Quinlan asked if the effect was then to redistribute provider revenue. Several Council members commented that was clearly understood to be the effect.

Chris Koller pointed out that there was much that was unknown about the size of the required increased payments to PCPs and where they might come from. Are the plans assuming that hospital rates are fixed and changes in utilization are impossible? Then any money to pay for pcp rate increases would have to come from lower (or lower increasing) specialty rates. But why is that a fair assumption?

Could plans achieve these targets by involving some other providers in the payment and contracting that would be necessary? Politically, this would have the effect of separating the opposition.

After more discussion about possible unintended consequences and the need for good monitoring, Pat Mattingly suggested the following:

That the goal of this process be rebalancing the delivery system and thus that the goal for a PCP spend measure reflect that. More specifically, while the baseline remains to be calculated, a five year goal to add a percentage point a year, - putting RI well ahead of any other state that we have found but lower than integrated health care systems like the staff model HMOs and no where close to other countries such as the UK and Spain - seemed reasonable.

No vote was taken but there was consensus among the Council members that staff should prepare a goal that reflects this, after clarifying the baseline with the plans.

C. Year-to-year standards for health plans: absolute goals or relative improvement?

There was considerable surprise and concern among Council members that United's draft primary care spend model was two points higher than BCBSRI, given that it is generally accepted that BCBSRI's primary care fee schedule is more generous.

OHIC staff stated they believe the calculations were consistent and the differences were due entirely to differences in sickness of the two plans risk pools. In the small group market conduct examination, United had markedly lower revenues per member and expenses per member, indicating a healthier population. This denominator effect completely overwhelms any numerator differences.

Several Council members asked if it was possible for OHIC to account for this difference analytically, to make comparisons easier. Chris responded that such "risk adjustment" is complex, expensive and not fool proof.

Peter Asen said that given this, the emphasis should be on the overall primary care spend rate of the commercial insurers, and then backing into the spend rates by commercial insurers necessary to achieve them, assuming current risk pools. This would imply asking for relative improvements by plan, rather than having them shoot for common targets.

Several Council members commented on the temptation this would create to have health plans recategorize existing expenses as primary care to hit any imposed target, and the need for OHIC to have good monitoring and even auditing processes in place.

Staff will prepare targets for proportional improvements by each plan to achieve an overall goal, assuming current risk mixes.

D. Medical Home and EMR standards: should the Council be more specific about alternatives to fee-schedule increases?

The Council reviewed the proposed standards and several technical questions were answered. Michael Bailit clarified that the EMR standard did not specify take up rates, but just that such an incentive program be in place.

Michael Bailit reviewed financial estimates that show that at current anticipated implementation rates, the medical home and emr standards did not consumer a significant portion of the increased plan expenditures to pcps that would be needed to hit the spend rate targets. Chris Koller noted that this raises an important policy question for the Council: How prescriptive does the Council want to be about how increased expenses to primary providers should be spent, and where the money should come from? Absent guidance there is a risk that plans – for instance –could take the path of least resistance: put all the money into primary care fee for service codes and take them from specialty codes. This would trigger a number of unfavorable consequences. However, the adverse consequences of the government being too prescriptive with private entities are also well documented.

Bill Martin spoke strongly for broad target and room for health plan action, with monitoring and guidance by the Office and the Council.

Pat Mattingly warned that without good guidance and monitoring, plans would in fact take the path of least resistance, given the other pressures they face. Several Council members pointed to places in the standards document that called for review by OHIC as being places to start.

No Council member spoke former prescriptive standards at this time, noting that there is too much that is unknown.

Staff will add clearer monitoring steps by OHIC.

D. Proposed impact assessment

Michael Bailit reviewed the proposed impact measures. Council members asked that a measure for ambulatory care sensitive ER admissions be added. Other comments concerned:

- The importance of monitoring and the need to prioritize this activity, especially given the political pressures this will likely cause (see above conversation).
- The need to set goals for each of these measures.
- The low likelihood of early improvement in these measures state-wide, given the long lead time required to see any results from spending more money on primary care.

Staff will add the ER measure and add text to reflect these comments.

E. Evaluation template – consequences for not meeting standards?

There was not time for a full discussion of this section. St the request of Council, staff had developed a proposed penalty schedule. Council feedback was mixed:

- Could penalties go towards primary care benefit., not just reduced trend rates?
- Should there a fixed portion of a penalty so as reduce “partial credit” implicit in what is suggested?

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- Should there be any penalty in year one, since this is new and health plans may miss because of reasons they can't control (like specialists churning up volume).

No conclusion was reached. Staff will present this suggestion as a potential model and leave it for Council action next year, since this process would not be implemented for two years.

5. Allowable administrative costs.

This topic is on the Advisory Councils agenda for this year. It is now apparent that it will be impossible prior to the spring rate factor filing to have an adequate review of it. Chris and Rick suggested that it be postponed until next year, that a process be employed with an outside consultant –similar to the reserves study a few years ago - but that plans be asked to present at the April meeting their justification for why administrative costs should be allowed to inflate at the rate of over all premiums.

The Council agreed with this course of action.

The meeting then adjourned.

Next Meeting of the Council

March 24th (*note – one week later*)

4:30 pm DLT Main Hearing Room

Topics

- Solicitation of Public Comments on draft Affordability Standards, based on Council recommendations.