

Health Insurance Advisory Council
April 20, 2010
4:30-6:00 PM – Department of Labor and Training, Cranston, RI

Minutes

Attendance:

- Members: Bill Martin (Co-Chair), Chris Koller (Co-Chair), Rick Brooks, Howard Dulude, Joel Cooper, Pat Mattingly, Phil Papoojian, Hub Brennan, DO, Gregg Allen, MD, Karen Fifer Ferry, Jeff Swallow, Monica Coughlin,
- Health Plans: Patrick Ross, Tom Boyd, John Lynch, Jason Martiesian, Lauren Conway, Craig O'Connor
- OHIC Staff: Adrienne Evans, John Cogan,
- Not in Attendance: Bill Schmiedeknicht, Roland Benjamin, Peter Asen, Robin Benoit, Peter Quattromani, Ed Quinlan,
- Guests: (public attendees)

1. Introductions
 - Members of the Council introduced themselves.
2. Minutes
 - Minutes from the March 23, 2010 were approved with editorial and typographic corrections.
3. Updates
 - Federal Health Reform: a work list of items regarding changes in commercial health insurance resulting from the recently passed Federal Health Reform was distributed. States now are monitoring the Department of Health and Human Services for regulations and guidance on each of these issues. First up: subsidies for high risk pool, extending dependent coverage to all kids under 26 and medical loss ratio guidelines. OHIC's first role will be to understand how federal changes effect state regulations and OHIC operations. Meanwhile, businesses are effected too and are looking for guidance.
 - OHIC is greatly concerned about workloads resulting from these changes and expectations of the Office for communications. It will update HIAC quarterly on implementation and bring policy decisions to the Council.
 - There were questions about under 26 coverage – information on this must come from HHS – and the high risk pool funds. In RI these \$\$ would probably go to subsidize the purchase of Direct Pay insurance for sick individuals. However only people uninsured for six months are eligible, and the State has made no decision about whether to pursue.

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4. Discussion Topic 1: Rate Factor Process for 2011: Data to be requested from Plans.
 - Rate Factors to be used in 2011 by health plans are to be submitted by Mid May and acted on by mid June. The purpose of this topic was to get feedback on items of focus in this review process and what information should be requested from them.
 - Priorities: Mr. Koller reviewed a handout which noted OHIC's priorities for rate factor review:
 1. Trend analysis
 2. Reconciliation of previous projections to actual experience.
 3. Administrative Costs
 4. Consistent categorization of administrative costs (concern expressed by health plans)
 5. Improved understanding of what is driving inflation trends.
 6. Business community education
 7. Coordination of system improvement activities (Dr. Brennan noted that United had disbanded its QTAC committee which it consulted for investments in local improvement activities, United has also announced it will not be supporting the ICU collaborative of the Quality Institute. Dr. Brennan said this was an item of concern and these are separate from the affordability standards of the HIAC)
 8. Continued emphasis on OHIC Affordability Standards
 9. Awareness of contested rate review process in Massachusetts and the context of Federal Health Reform
- Historical Data: Mr. Koller noted that OHIC would not audit the data submissions of the plans, although it has been discussed in the past. This would be a longer and more resource-intensive process than can be accomplished in the one month period allotted here.
- Dr. Mattingly asked if it was possible to do a more definitive analysis of cost drivers in the health plan submissions – even it meant doing the analytical work – to understand trend drivers. Mr. Martin expressed concern that managing trend was the job of the health plans – and this sort of activity verged on micromanagement. Ms. Fifer Ferry concurred saying it would be more appropriate to ask the health plans to do the analysis.
- Administrative Costs. The Council re-reviewed information distributed to them in November about trends in Health Plan administrative costs. The Council has continued to take an interest in these costs. Phil Papoojian clarified trends in broker commissions. Health Plan officials clarified that numbers for 2010 were projections done in May of 2009 for 2010 and thus were not particularly accurate – they believe their projections for 2011 will be more accurate.
- Mr. Martin indicated his belief that the rate oversight process should assure that administrative costs rise no faster than general inflation. Ms. Fifer Ferry said that she agreed and that she thought health plan administrative costs were too high – but allowances should be made for the fixed costs in a health plan. The measure should be a per capita figure – not a percentage of premium - and the variable portion of that cost

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should certainly trend at general inflation. Rick Brooks concurred and stated that plans should be asked to justify these trends.

- Discussion then turned to the effect of self insured products and their pricing on administrative costs. Mr. Martin said that from his analysis it appeared that BCBSRI was shifting more of its administrative costs to the fully insured market, presumably in response to price competition on the self insured business. United – which prices its administrative costs as fixed percentage of premium based on a contract with its parent - does not have this issue. Mr. Koller stated that the services provided under a self insured contract are different from those provided under a fully insured contract. He also stated that while insurers compete on the price of admin services on the self insured business – they do not appear to on fully insured; regulation of these costs becomes an alternative. A council member asked if the cost allocation methodology between products was reviewed. Not by OHIC , Mr. Koller responded. Large public purchasers – Medicaid and Medicare – do however, a BCBSRI representative noted.
- Howard Dulude noted there would be increased oversight of Health Plan medical loss ratios – and thus the definition of Administrative costs – with Federal Health Reform. OHIC, therefore, should not invest much in setting its own rules in this area.
- Mr. Koller summarized that based on this conversation, OHIC would ask for the following additional information, besides the administrative costs information and projections collected last year:
 1. Self insured enrollment
 2. What the health plans use as pmpm benchmarks for their administrative costs.
 3. A categorization of administrative costs by the plans as fixed or variable, with an explanation as to why.
 4. An explanation for why administrative costs should trend at higher rates than general inflation

Other information in the rate factor filing:

- Mr. Koller noted that because of the supplemental budget, the Office could not conduct the annual provider survey. The RI Medical Society has been solicited to fund the costs of the survey, which are not significant.
 - A survey of health plan contracting methods with hospitals will be conducted, as a precursor to OHIC Affordability Standard number four – broad payment reform.
 - A second round of the hospital pricing analysis will not be conducted as part of the rate factor review but will be done separately to include Medicaid and outpatient services – this would be a large analysis.
5. Discussion Topic 2: Review of Affordability Standards
- This was the quarterly review of the health plan performance on OHIC Affordability Standards. Mr. Koller presented a power point summarizing the work so far. The analysis was very preliminary as there were no claims to review for 2010
 - The key takeaways Mr. Koller said are the following
 - Health Plans are making good faith efforts to comply with the standards.

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- It is very difficult to speak in terms of dollar amounts to invest because projections have change considerably since the fall of 2009 – due to membership declines, primarily. This is important for setting physician expectations.
 - Health Plan primary care spending in 2009 went up considerably from 2008, giving them a head start on 2010 standards.
 - In planning for the future, it is probably more appropriate to think of a small number of categories of spend, rather than a larger number, because of the inexactness of the budgeting process. How are these investments determined: There is an ongoing tension between identifying priorities for the plans and asking the plans to innovate on their own.
 - The affordability standards will require ongoing attention and monitoring. Compliance by the plans will only get more difficult.
 - Efforts at evaluation and baseline measurement have not made satisfactory progress so far.
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- In terms of prioritization of projects, Dr. Brennan said “all payor is the way to go. If that means directing the plans, so be it.”
 - Dr. Brennan said that it would be important to make sure the investments serve the larger goal of improving the primary care infrastructure in the state. Mr. Martin noted that the reasons this is important is because of the expected effect on cost trends and this would have to guide the investments.
 - Ms. Fifer Ferry said she would like to see the plans be given a chance to innovate rather than be told what to do. However, others noted that this diminishes the likelihood of coordinated investments and if this is a public policy, should the priorities be determined that way as well?

6. Other Business: None

Next Meeting

May 25, 2010. (changed)

4:30 pm – Landmark Hospital, Woonsocket, RI

Agenda:

- 2011 Rate Factor submissions by plans.
- Administrative costs analysis

The meeting then adjourned.