

**Health Insurance Advisory Council**  
**May 25, 2010**  
**4:30-6:00 PM – Landmark Medical Center, Woonsocket, 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, Monica Coughlin, Bill Schmiedeknicht, Peter Asen
- Health Plans: Patrick Ross, Tom Boyd, John Lynch Jason Martiesian, Lauren Conway
- OHIC Staff: John Cogan,
- Not in Attendance: Pat Mattingly, Roland Benjamin, Robin Benoit, Peter Quattromani, Ed Quinlan, Jeff Swallow
- Guests: (members of the press)

1. Introductions

- Members of the Council introduced themselves.
- Bill Martin noted that this meeting was being held in an alternate location to comply with OHIC statutes. No members of the public were in attendance – OHIC posted notices on its web site and in e-mail messages. Because the main topics of the meeting were the proposed rate factors to be used by the health insurers in 2011, Council members were interested in obtaining public opinion. The lack of attendance, he noted, could be due to the fact that the rate factors had only been published late the previous week - or OHIC's publicity efforts need to be more extensive.

2. Minutes

- Minutes from the April 20, 2010 meeting were approved.

3. Updates

Federal Health Reform:

- High Risk Pools – RI has made no decision on whether it will elect a state option or the federal fall back for using its allocated high-risk pool money. The funds would cover about 500 people a year and the state option would designate BCBSRI to contract directly with the federal government and develop a product along side its Direct Pay products. RI can designate its choice as early as June 1 and must decide by July 1.
- Medical Loss Ratio – Federal law requires minimum medical loss ratios for small and large group products and asks the national Association of Insurance Commissioners to develop a definition for use. The Secretary of HHS could order health plans to rebate money to

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- consumers when MLR's figures are lower. RI is not participating actively in the MLR definition discussion.
- Rate Review – The law gives the states grant money to document and improve their rate review process. RI is very aggressive in this area and will be applying for these funds.
  - Web Portal – Federal Law requires HHS to set up a consumer web portal based on information obtained from states. There have been several planning calls with the states to discuss the information to be collected. It appears it will be a tedious and time consuming process – definitions vary by state as do data collection procedures. It is also not clear how useful the final information will be to the consumers.

### Affordability Standards

Chris Koller updated the Council on meetings with the plans regarding compliance with HIAC's Affordability Standards. United demonstrated plans for compliance with the 2010 Primary Care spend targets while BCBSRI has not. Council members expressed concern with BCBSRI's inability to document plans for compliance. OHIC will be following up with them.

The Rhode Island Foundation has announced that its strategic initiative in health care will be in the area of primary care. They are convening community leaders on the topic at the end of May. This creates good alignment with the direction of the Council to the Plans. For instance, the Foundation has established a loan fund for residents in Primary Care specialties who stay in Rhode Island. Health plans can also contribute to those funds as part of their primary care spend.

Monica Coughlin noted that there are several components of the Federal health reform law that are consistent with the Council's Affordability Standards – including Medicare Payment Reform, requirements on the coverage of preventive services in insurance policies and the promotion of primary care,

Bill Martin noted that it does not feel to him that progress is being made with the affordability standards – has the practice environment improved for primary care clinicians with increased attention from the insurers? Are the patient centered medical home efforts resulting improvements in health system performance? He said he recognized that such changes would take time, but noted that the Council should stay focused on these goals.

#### 4. Discussion Topic: Rate Factor Process for 2011: Data submitted by Plans.

Chris Koller reviewed the information submitted by insurers, which was the most extensive set to date:

- Attachment A: Rate Factor – OHIC Considerations (a "scorecard") and rate Factor submissions by plans
- Attachment B: Survey of Contracting Practices by health
- Attachment C: Budgeted Administrative Costs by NAIC cost category
- Attachment D: Historical Administrative Cost Trends
- Attachment E: Survey of Resources for Health Systems Improvements

In addition, a physician survey is being administered by OHIC.

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Bill Martin suggested that the group focus on the large group rates as a way to narrow the conversation. Council members noted:

- The differences in predicted utilization inflation rates among the plans. Was this because of population differences, benefit plan differences or estimation differences?
- The high rates of price increase for hospital services across all plans. There was concern expressed about this by the members.
- The need to reconcile past performance against what was requested/approved in previous years. This is clearly a needed enhancement but is hard to do, particularly in the compressed period between filing and a decision.

Mr. Martin and Mr. Koller then focused the discussion on the relevance of the Council's Affordability Standards. If successfully implemented, these would reduce the trends. However the submitted rate factors and the responses to the provider payment survey make it clear that comprehensive payment reform is not happening between health plans and providers. Mr. Koller noted the survey responses also show how little innovation exists in the area of payment reform – the reasons can be speculated about but are not apparent. What is the role for the Council and the rate review process in promoting greater amounts of payment reform?

Peter Asen asked if health plans have sufficient leverage with hospitals to promote payment reform. It does not appear they do, he said – as evidenced by the BCBSRI/CNE negotiations. Are there benefits to learning from or standardizing on Medicare?

Karen Fifer Ferry said that, under pricing pressure on health plans, hospitals in Mass are starting to be more willing to discuss payment reform ideas – including shared savings accounts. But change is hard and flexibility is important for hospitals.

Hub Brennan and Bill Martin both expressed concern that the price increases reported here for hospitals reflects underpayments by public payers. Rick Brooks said this has been a historical pattern. Chris Koller noted that is the conventional wisdom. There is no public data however on this issue.

Besides the pricing issue, Mr. Martin noted, there remains separate issues of insurer administrative efficiency (see discussion below) and utilization inflation – which would be taken on with payment reform.

Howard Dulude spoke of the need to take a long-term view – health plans and hospitals should have expectations set for where they should be in five years – a targeted rate of increase at the end of that period. They need to plan, given those community expectations.

Phil Papoojian noted that he has to reduce his costs – as a supplier – when his customer tells him what the market price is. He has no choice. But as a health insurance purchaser, he has no idea about “supplier prices”. And it is as if he is just paying whatever they define as their costs.

Karen Fifer Ferry said we should not assume that starting prices are fair and therefore we should just limit the rates of increase. They may preserve inequities or inefficiencies. This generated a conversation amongst the Council on the merits and drawbacks of increased price transparency.

Chris Koller asked Council members how to create the expectation that the delivery system has to change - consistent with the affordability standards

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- Howard Dulude pointed to the power of organized purchasers in communicating the expectation that trend must be lowered.
- Rick Brooks said that policy makers should be aware of unintended consequences, such as the failure of financially weak providers. He noted that coordinated health planning would help address this by setting common goals and expectations.

Chris Koller indicated that the guidance he was taking from the Council was that the rate review process could promote the affordability standards by setting expectations for the long term rates of increase for both insurers and providers, and enforcing the expectations with the decisions on the rate factors.

The second major area of discussion was the projected administrative costs and reserve contributions.

Several Council members said they were deeply troubled by the lack of specificity in BCBSRI's administrative cost projections; while they reduced their administrative percentages considerably from previous filings it was not clear how they would do so. Karen Fifer Ferry supported approving a specific per member per month expense fee as a way to encourage efficiency.

Hub Brennan noted BCBSRI's declining enrollment – which greatly affects its efficiency. Peter Asen asked to what extent this was a function of pricing and lack of competitiveness, or the weak RI economy. Council members noted this raised a larger question of whether the RI economy was big enough to support an independent non-profit insurer.

Chris Koller said the weak financial performance of BCBSRI means that contributions to reserves could be appropriate. The filing from BCBSRI did ask for .5% for its IT system – up from .33 in the past – and a new request of .5% to fund the company's strategic plan.

Price competition from self-insured business also puts more pressure on the fully insured products. Council members asked if it was possible in the future to understand the cost allocations between the two businesses.

Similarly – as in the past – concern was expressed with structure of United's administrative services agreement, which guarantees it 12% administrative costs plus local expenses. This is based on an approved agreement between the parent company and the local health plan.

There was no formal direction from the Council on the topic of administrative costs

### Next Meeting

June 22, 2010. (changed)

4:30 pm – DLT, Cranston, RI

#### Agenda:

- 2011 Rate Factor status.
- Federal health Reform update
- Legislative wrap up
- Planning for HIAC – 2010/2011

The meeting then adjourned.