Health Insurance Advisory Council
December 21, 2010
4:30-6:00 PM – Department of Labor and Training

Minutes

Attendance:

Members: Bill Martin (Co-Chair), Chris Koller (Co-Chair), Rick Brooks, Howard Dulude, Pat Mattingly, Peter Quattromani, Ed Quinlan, Herb Gray, Linda Lulli, Gregg Allen, MD, Jeff Swallow, Bill Schmiedeknecht, Phil Papoojian,

Health Plans: Brian O; Malley, Patrick Ross, Gus Manocchia, MD, Brian O'Malley, Anton Dodek, Mack Johnston

OHIC Staff: Angela Sherwin, Adrienne Evans

Members Not in Attendance:
Roland Benjamin, Hub Brennan, DO, Peter Asen, Jack Spears

Invited Guests: Paulette Thabault

1. Introductions
   - Members of the Council introduced themselves.

2. Minutes
   - Minutes from the November 16, 2010 were approved.

3. Updates
   - Staffing Changes: Angela Sherwin was introduced as the Principle Policy Associate – hired with Federal Grant Money. Herb Olson will be starting as Staff Counsel in January
   - Transition Planning: Chris Koller said all Agency Directors are meeting with the Governor-elect to discuss budget and policy issues. The Commissioner is a gubernatorial appointee.
   - CNE Lawsuit of OHIC. Chris Koller reviewed a lawsuit of OHIC filed by Care New England. The first part of the lawsuit – contesting the applicability of the OHIC contracting standards was settled out of court. The second part – on the authority of OHIC to issue an order of BCBSRI resulting from its contract with CNE and make its examination report public was not settled and will go to hearing.
     - Discussion focused on the settlement by OHIC and CNE, the result of which was an exemption of United from the contracting conditions for the CNE contract currently being negotiated. Council members expressed support for the contracting conditions, disappointment that the lawsuit was filed, disappointment at its resolution and disappointment that the resulting contract terms will be confidential. Chris Koller indicated that since some questions were raised about the process used by OHIC – in attaching the standards to a rate decision – the Office will issue them in regulations.

- Ed Quinlan noted that in his opinion the presentation of data to the Council by representatives of the Department of Health at the November HIAC meeting – while addressing a legitimate public interest - was premature, particularly because hospital specific data was not risk-adjusted. Hospital Association of RI officials are now meeting with Health to review the data, he said.

4. Discussion: Standards to be used by OHIC and Health Insurers in Defining Primary care Spend.

Chris Koller introduced this topic and explained its relevance. As the requirements for primary care spend increase, health insurers are raising other potential spend categories and asking for guidance from OHIC. This seems an appropriate topic for the Council, Mr. Koller said.

Angela Sherwin gave a brief presentation, which included four columns of spend based on proximity to primary care doc: payments to doc, payments for services at the doc site, payments for services to other providers not at the site, and investment in infrastructure. The presentation concluded with three questions:

- How narrowly should primary care spend be defined?
- Should the spend requirements be sequenced?
- Should they be coordinated across plans.

Bill Martin asked the health plans to comment first.

- Tufts urged that they be budget neutral and might have to include payments for physician infrastructure to build their capacity to manage financial risk.
- Blue Cross noted that the spend requirement if fully implemented would result in huge amounts of dollars going into primary care, and it was not clear how practices could absorb that money and demonstrate improvement with it. Therefore Dr. Manocchia advocated a broad definition which include spending for services that connect to primary care, so as to improve the ability of primary care practices to deliver the desired improvements. He also noted the lack of reliable performance measurement reporting to identify successful primary acre and specialty practices.
- United advocated for a narrower definition and more direction from the regulator.
- Neighborhood – although not subject to the standards – advocated for a a narrower interpretation that focused on providing resources to primary care practices to improve care coordination – the patient centered medical home concept.

Mr. Martin then asked for comments from primary care physicians in the audience. He also noted the letter from Dr. Borkan at Brown. These comments included:

- place priority on payments to primary care physicians, practice innovation and loan forgiveness. There is enough money out there for specialists and hospitals – perhaps it has to be redeployed.

Comments from the Council were then made.

- Should OHIC be identifying priorities or programs within these categories? If yes, what would they be?
- Hard to do that though without some objective results.
- Should primary care spend include EMR incentives and standardizing on an EMR or are there sufficient monies elsewhere for this work?
- The first two columns seem reasonable – money to other provider and for infrastructure is harder to justify, particularly given the existing salary gap for primary care.
- Consider whether payments to other providers through primary care docs could count. This has effect of putting them at center and building the capacity Tufts talked about.
- We don't have enough information to make specific recommendations.
- Loan forgiveness is really a payment to physicians – should not be thought of as infrastructure.
- More comments from primary care docs will be helpful.
- As to the amount of alignment in investments that OHIC should require:
    - It is hard to require alignment if we are not sure what works. That guidance should come from learning projects like CSI.
    - It would seem that adequate fee for service is the first priority. Evidence from OHIC indicates that United has done just that. BCBSRI has spent less money on fee for service and more on other programs. United will soon be in same position.

Chris Koller summarized the conversation as follows:

- Spending to primary care docs (including loan forgiveness) and at sites is appropriate. Spending to other providers and for infrastructure should be considered only with justification.
- Absent better information on what works, it is hard to justify specific priorities or force alignment across health plans. The information on what works should come from the all payor project and the health plans themselves.
- There is no need to have specific limits on fee for service payments – plans will pay what they have to and spend the other money in other ways.
- This guidance should not be final but needs more input from primary care doctors.

OHIC will develop drat guidance based on this discussion and circulate for public comment. It may come back to the Council for formal review.

Other Business

None

Next Meeting

January 18, 2011
4:30 pm – Department of Labor and Training.

Agenda:

- Anticipated language for Revised OHIC Regulation Two, Incorporating Affordability Standards/

The meeting then adjourned.