

Exchange Work Group
Monday April 23, 2012
Meeting Minutes
7:30am

Attendees: Michael Varadian, Mark Deion, Kim Paul, Dawn Wardyga, Rachelle Dunning, Domenic Delmonico, Mark Kerrin, Chris Koller, Jason Martiesian, Tom Dwyer, Owen Heleen, Stacy Paterno, Monica Neronha, Jim Borah, Chris Kent, Scott Deluca, Carrie Bridges, Sandy Ferretti, Rebecca Kislak, Linda Johnson, Jeff Mineuto

- I. Call to Order – Angela Sherwin, Office of the Health Insurance Commissioner, began the morning welcoming members. She noted that while Qualified Health Plans (hereafter QHP) were originally scheduled for discussion later in the year, but due to time constraints and to ensure that we meet all the deadlines surrounding this topic fully informed, we would like to begin the conversation now.
- II. Presentation (slides available upon request)
Questions/Comments throughout presentation:
 - a. Domenic Delmonico; Are the plans required to offer products that have an actuarial testing to them, is that property of the exchange or will that happen elsewhere.
 - i. Angela Sherwin: At minimum there is an actuarial value test that will classify plans among the metal tiers, and the actuarial soundness is part of rate review.
 - ii. Chris Koller: there are two actuarial levels, one to see if the exchange agrees with the issuer’s classification level. The other is the dollar value and full insurance regulatory review. Every state may do it on its own; our assumption is that RI is so small that the exchange may take the lead on that.
- III. Discussion
 - a. Scott Deluca: All along there is the concept of if you build it they will come – how are folks going to learn about how to sign up, how to participate. Will it be the health plans, the users etc?
 - i. Angela Sherwin: While we haven’t discussed the details yet, we presume it will be the exchange, and working with the plans. Certainly will be coming back to this group with
 - b. Mark Deion: Talked about making it affordable and dealing with a population who cannot afford this now, at some point is there a financial benchmark, and below this number is where folks enter the exchange, and then from an actuarial standpoint what needs to be paired out of the plan, and then the third is a need for critical mass. If you want to encourage folks to participate then the plan needs to be less than what currently exists. If the exchange is going to be an active purchaser then it needs to negotiate.

- i. Angela Sherwin: Those three components, do you believe they should be a part of the exchange work specifically, or do you believe it should be applied more broadly.
 - ii. Mark Deion: If health insurance is not affordable today to a certain level of the population, then feel the premium needs to go in reverse. Have enough of critical mass to negotiate – even if one is an active purchaser, folks can say they do not want to participate.
 - iii. Angela Sherwin: The programs and products that has worked well with to date are RItE Care. Have to be particularly creative to meet goals.
 - c. Commissioner Koller: Have a question or folks here – QHP are in a way consumer protections, which harkens back to a time in the past. What is going to happen - how is that going to integrate and apply to these plans. How does what we have now relate to what we are discussing here, and how do we wish to have that work with the exchange.
 - d. Jason Martiesian: It is an important question that the Commissioner just raised about what the consumer protections are. Our view is that we do have a number of consumer protections, we do have laws and regulations that provide for fairly robust plan design. Are we viewing the exchange as almost separate, what is offered inside the exchange, would it be available outside as well? The other piece is that, in our view, providing choice or standardization, there is an opportunity to do that inside the exchange, we are a small population and where the basic health plan goes, thus to have a level of choice that does not minimize, those products can and will, thus the question to have is when looking at those products, are you looking at standardizing the level of coverage, certain deductible and copays, or looking to current products offered today, and there are United's gold, silver, etc.
 - i. Angela Sherwin: Not looking at either of those models today.
 - e. Dawn Wardyga: On the consumer protection piece, there are a great number of consumer protections in place, but the problem is that folks do not understand what protections are in place or how to exercise those rights afforded by the protections. On the other end of the spectrum, when it comes time for utilization and denials etc, what I have found is that there are more consumer protections in place than consumers are actually aware of, and there is a gaping hole in information in consumer assistance programs. When in a serious health situation, the last thing one wants to do is knock heads with an insurance company. Need to do a better job of informing people of what the options are when they have questions, or when they want to file an appeal. This is where I see the biggest hole that needs to be addressed.
 - i. Angela Sherwin: Perhaps broader than standards for QHP specifically.

- ii. Linda Johnson: Be able to back that up with programs and assisting those people, with those statutes that happen right now, avail themselves to the consumer. Unable to support what we have right now based on the way the system is set up. Add QHP and a campaign to inform folks, and the current system is drowned.
 - iii. Commissioner Koller: What I am hearing, it is not so much new stuff, but rather building up what and informing on what is out there.
- f. Rachelle Dunning: We have United healthcare with 2500 employees, with several on set reps, and several available meeting points for employees to be informed and there are still individuals who are unaware of the point. This will be a challenge on a state level.
- g. Domenic Delmonico: Perhaps this should speak to the goals on the exchange – how do you have a baseline to know that one is gaining ground. Health literacy. The other concern is that if the exchange is now the active purchaser how do we link it to individual accountability?
 - i. Angela Sherwin: That is an example of perhaps including wellness products on the exchange.
- h. Mark Deion: Health pact, if one did not have a PCP and went to the emergency room, one's co-pay was outrageous. Sympathetic to the insurers and regulators, but less sympathetic to the subscribers as there are those who have BCBS or United basic plans, and I know folks who use the ER as their PCP. There is a responsibility to change the mentality of the user and ignoring the basic purpose of it.
- i. Commissioner Koller: Health Pact was an attempt to define a benefit design that would result in an average lower cost. There was a product design that health issuers were under law required to offer this plan and it identifies four wellness behaviors that one is incentivized to adopt with the product – select a PCP, commit to maintain a healthy BMI, commit to stop smoking, and if have a chronic condition then qualify with case manager. Under the product design if you committed to those four things, then really low co-pays, if not, really high co-pays. Those plan attributes are now appearing in different plans offered by insurers. Conceivably those could be standards the exchange could adopt under wellness for all products offered regardless of the precious metal level.
 - i. Domenic Delmonico: The challenge is that monetary incentives will not do a lot for the subsidized product.
 - ii. Commissioner Koller: It is a fundamental model for the exchange. Too prescriptive with our benefit design in health pact, exact level of cost sharing etc.
 - iii. Domenic Delmonico: That is the challenge, how to motivate folks to do the right thing, not sure that monetary changes will make a difference, especially on the subsidized product.

- iv. Angela Sherwin: There will be products and some folks will get subsidies for those products, and unlike the MA model there are subsidized products and unsubsidized products, this exchange will provide products, and then some participants will be given a subsidy to those available products.
- j. Mark Kerrin: Are there enough primary care physicians to take on 60,000 covered lives?
 - i. Angela Sherwin: Believes there is some sort of study in the works. There is a PCP survey out through the dept of health right now.
 - ii. Commissioner Koller: PCP supply is relatively good. MA has contended that the issues is less PCP access and more to the services of all health reform. Perhaps there are more waiting times.
 - iii. Domenic Delmonico: And perhaps part of the answer too is what constitutes a PCP – perhaps broaden that definition to another care-giver who may act in that role, i.e. ob/gyn.
 - iv. Stacy Paterno: Are we being thoughtful about the PAs and NPs, and realistically about what we can do with them.
 - 1. Linda Johnson: Also concern about the reimbursement structure, may need to realign if the definitions change.
- k. Carrie Bridges: The role of the care coordinator and how to qualified plans and to have sufficient...
- l. Linda Katz: It may be helpful to review what RIte Care has done with wellness and to control cost, as well as with the consumer market and see what that list is to compare. It can address the strategies needed for lower income talking about different income level below FPL qualifying level etc.
- m. Monica Neronha: I would say that at the Experts there was a concern about the active purchaser model, and the harder it will be to maintain carriers in the marketplace. Be careful about building too much structure in the exchange as that is potential risk that one is running, and that the more regulatory structure you build around that, the harder this will be. It is important to hear that point, as these are the people one needs to sell on the exchange.
- n. Commissioner Koller: Some of the standards can be moved back and forth between the plan and the issuer. Accreditation for example, could be at issuer level inside and out, or in plans in the exchange. Based on what Monica was saying, the relative merits of having these discussions at the issuer level vs. the health plan level, for the latter may be more restrictive. I am unsure if given the balance of consistency, and not the right level of regulatory oversight, the question perhaps should be what should be the issuer level and what should be at the exchange/plan level.
 - i. Monica Neronha: I think it is a great questions. Something like accreditation is fairly costly to implement. Finding a way to sit

down and think through all of these things, what provides the correct protections for consumers both in and outside the exchange. Having reasonable approaches across the whole board that attract consumers.

- ii. Jason Martiesian: Maybe it is instructive or insightful to talk about what Medicaid and the carriers are doing today. If we have an assessment of what is happening today that is helpful. I think RI is in a good place compared to other states, but it is important not to be limiting. To understand exactly what folks are looking for but not to limit to the exchange population.
- o. Angela Sherwin: We can also distribute to this group the payment/delivery reform work group report which may help be a part of this conversation.
- p. Stacy Paterno: What is the current process or thinking around the Basic Health Plan?
 - i. Jennifer Wood: there is authorizing legislation pending in the general assembly, unclear if it moves this year, as there is not sufficient information from the federal government to make a policy decision on how it would impact on this.
- q. Jennifer Wood: Active purchaser took on two lenses this morning, in terms of the parameters for plan, and then the second in terms of parameters for enrollees. There was a lot discussed about health pact and innovations regarding using incentives to access care. How do your comments about being a viable place for products relate to the second layer the active purchaser vis a vis the patient.
 - i. Monica Neronha: If I recall, there was some conversation about consumer engagement – to me that is really different than active purchaser. We are very worried about the ability to move plans with the marketplace based on what consumers want and what the market wants; I think Health Pact is fairly defunct. It was innovative when we built it, we have not kept up with the plan design. As it has an artificially low price point, and it worries me that we have a plan out there that is not pacing to what it can be. It is a demonstration of how a prescriptive plan design does not always keep up with the rate at which the market makes demands. What you have the potential of seeing. Who is to say that we won't have United with a deductible plan of 500.00 and BCBS with a plan of 1000.00 and both have an actuarial value of gold, and why is that okay. The consumer piece is key.
 - ii. Linda Katz: What do we know from MA – monitor lessons learned.
 - iii. Stacy Paterno: There are products in the market right now that have extremely high deductibles, the problem is from the provider perspective that is difficult to help consumers understand what that means. It is hard for the patients to

understand that the doctor may be losing out on this too.
Address this issue as we move forward as well.

- iv. Monica Neronha: Explain what the tradeoffs are and why you are making these decisions and what are the implications.
- v. Linda Johson: Are we shifting costs to provider groups? Be aware of the problems we are facing. Explain that to people.
- vi. Commissioner Koller: A bronze plan doesn't change what you pay, it changes where you pay.
- vii. Angela Sherwin: Not only is it health literacy but health insurance literacy.
- viii. Will it be the role of the navigator to help with the consumer piece, with the literacy?
- ix. Linda Johnson: That insurance company contracts with that person, then the person goes into the provider office. Shouldn't there be a conversation between the insurer and the consumer, not just provider?
- x. Angela Sherwin: As we define what the role of the navigator is, how much information from the insurer, and we will continue to figure that out and bring that back to this group. To Linda's point about Massachusetts, there are two headlining lessons I can think of: the ability of the exchange to negotiate re premium and price. The way the connector could do that was it was purchasing on behalf of the subsidized population. The second is around the standardization that keeps popping up, a ton of lessons learned – health plans come give us gold, silver and bronze and timed by just actuarial value and consumers were still very confused, so the connector then swung the pendulum to the other side, noting that for each tier we are going to specify 25 different pieces of the benefit package. The list was quite lengthy and very prescriptive. This worked for consumer, but was not conducive to innovation from the carriers nor well received. Now they are trying to figure out what is the happy middle ground.

IV. Public Comment: No additional Comment made.

V. Adjourn – next meeting is May 7, 2012 at 8:30am.