

Working Group for Healthcare Innovation
Spending Cap Subgroup
October 13, 2015 – 7:30am.

- I. Welcome – Secretary Roberts welcomed everyone, and asked that introductions were made. She advised the group would meet in a larger space next time to accommodate the large interest in the topic.
- II. Discussion – Sam Marullo went through slides of a presentation to explain the topic at hand to provide a base for discussion. The slides are available online and available upon request via email to lauren.lapolla@ohhs.ri.gov.

Ted Almon: Premiums are key.

Al Kurose: Have any of these states tied premium increases or rate setting to the total cost of spending rate cap? Is there premium relief for those? Total cost of care spending is very important. Has anyone done that?

Sam Marullo: No, no one has done that yet. Oregon has come closest by mandating certain percent increases.

Ted Almon: What we were spending on healthcare before might have been too high. If it is unaffordable now, lowering the rate of increase won't help. We will have to think about what you we spend.

Al Kurose: At the bare minimum, we have to tie this premium to something. You guys are talking about different levels of nuanced sophistication, but even before we get to that level of complexity we need to look at this. Even tie the premium cap to actual performance on total cost of care.

Sam Marullo: Would OHIC like to comment?

Cory King: I think you have that direct link, even if you impose that cap. I am not commenting on the level of the premium or the level of spend.

Ted Almon: The administrative burden is still much larger than it needs to be. The 87:10:3 came from the 80s, from BCBS, and that was when they were smaller.

Paco Trilla: Our administrative number is right around 10%.

Kathleen Hittner: If we decide we are going to do that; affordability standards are really trying to get at the costs. I think the state in both the private and public sector is trying harder than before to control cost. I think we're starting to pay for quality. We should focus this discussion on the goal, and then what do we do to get there.

Lou Giancola: The other problem is when you look at the premium.

Sarah Nguyen: We talked a couple months ago with a group on a different topic, and they brought up the point about the concern over self-insured, that there want a clear path, but not a clear target.

Secretary Roberts: That is if you are following it from the commercial insurance side. The self-insured are in there, but not the uninsured.

Sam Salganik: I am curious, as I think the Massachusetts model has called out a special figure on the figure, tried to get at premium and to get at self insure to look at providers and at self insured.

Sam Marullo: That's right they hold both the providers and the payers responsible.

Al Kurose: I want to point out that based on the data at the October 7 (Working Group for Healthcare Innovation) meeting, we see that something is not working here. We saw data from '11, '12, and '13 that said there was a 1% increase in total cost of care. We need to see why premium increases were so much higher in a qualitative and a quantitative way. As we try to make this connection, we cannot take it on faith. I have trouble connecting the dots.

Cory King: We can certainly go back to the previous rate approvals and go back. Rate setting is a prospective exercise and you are making your best guess. The 11 – 12 trend was 4.6% overall, and that was in keeping with our rate of growth for the market. Then the '12,'13 trend was actually negative. If we had more recent data, we may see more recent trends, recent rate approvals. That is a good question and I wish we had more recent data will probably need to go back a bit.

Paco Trilla: There was a recommendation from the consultant that the pharmacy costs are the drivers. One piece the ACA left untouched is pharmacy, and we're subject to possible price gouging there. I don't know if there are regional or state wide ideas. I believe that pharmacy is going to become an issue, I don't know if there is a way to address that.

Secretary Roberts: There have been examples where states went 'rogue' - Maine did that, and the pharmacy companies said, 'fine, we won't sell there.' With a state of our size, it's going to be challenging without a regional approach. I think we need to find some ideas beside the generic approach to really tackle this.

Secretary Roberts: In Maryland, when they did the cap for hospitals, they built everything into services to ensure quality of care.

Sam Marullo: They haven't implemented a global cap yet. So far, they're only setting rates. They've set a target for the global cap, but it's a goal at this point. We'll see where they go from there.

Lou Giancola: We did try that in the past, in theory, as a means of capping expenses in a predictable way. At least for the BCBS population, we knew what the expenditures would be. We still had to file claims, so administrative costs did not go down for either of us, but I thought it was worth the effort. Al (Kurose) and I have had a discussion on a system like that with forced collaboration amongst the providers so that we are

rationalizing the system. It's worth considering in this discussion at a time when everyone is applying a different approach.

Unidentified Contributor: What happened most recently in Maryland is large-system development with Johns Hopkins, etc. really consolidating the delivery of care. They have been doing review work, and with CMS involvement they look at information.

Al Charbonneau: Maryland data, if my recollection is correct, is that it is not as high as say other areas. I think you need to consider those costs.
Sam Marullo: We did pull some data, Maryland was good at containing costs in the 1990s, but has grown in line with the national average since.

Paco Trilla: In Oregon, didn't they carve up the state into regions?

Ira Wilson: I was going to say that – they carved the state up into geographical areas, to help each region figure out how to do this. Very different way of thinking about this.

Secretary Roberts: Right, and driven by many of their Medicaid MCOs moving out of the areas, and moving the pieces around.

Ira Wilson: So far, early numbers are looking good for them – albeit only Medicaid.

Cory King: As a comment, the first meeting of the affordability committee will be this Friday at 8:00am

Ted Almon: [Re: Maryland] To what extent were the rates political?

Sam Marullo: Yes, they have control over hospital rates, they can set those. They do not control utilization.

Lou Giancola: They are 17th and we are 8th.

Cory King: We did not have an all payer estimate yet, and in November we will have the final report out there. The average was about 1.1% growth for the all payer average.

Unidentified Contributor: Looking at the increase, and Medicaid will now flatten out. Those things happen in a market that you cannot control.

Cory King: Looking at the average trend from '10-'11 in the Wakely data the total trend not including Medicaid fee-for-service was 1.1%, and on the commercial side was 1.4% across the entire study period.

Paco Trilla: Was the annual raise on premium 4%?

Cory King: I would have to look back, but in 2013 we had low rate approvals, but that was the year BCBS came in low, so - let me dig up that historical data.

Unidentified Contributor: That would be helpful, so for 2014 not falling to Medicaid. But really need to charge for that.

Lou Giancola: Are the CCOs provider based?

Ira Wilson: Yes, only provider based.

Unidentified Contributor: CCOs are a variety of provider groups, a new entity forming with the state, a new business entity that they contract within themselves.

Sam Salganik: My understanding that in some of the Oregon regions, the CCOs set capitation areas.

Lou Giancola: When we look at health care costs we do not look at them in relation to other costs, for instance, public health expenditures.

Secretary Roberts: There is a professor at Yale who defines it a bit more broadly, looking internationally and state to state on public spending, income support, traditional healthcare spending and looking at the proportion and the total amount. Internationally looking at the higher you spend on the social determinants side, they are just starting to look at the US and seeing how it is a coordinated effective way to manage. Public health is such a minimum investment in most states, most federal.

Ira Wilson: Yes, about 3% nationally, most federal.

Sam Marullo: Did they find positive return on investment?

Ira Wilson: That is not what they look at – rather explaining results of input in public health care and outcomes.

Sam Salganik: When we say we spend a lot on healthcare, we need to think about what we mean there. How do we have a conversation about cost, and about value? When those two things get divorced from each other, it seems tough to really move this conversation forward in a meaningful way.

Secretary Roberts: I think the other argument is: the proportion of our economic wealth, how much do we want to spend? There has been a determination that we spend too much on Medicaid for example. The initial concept is not to look at just value and outcome but how many people are managing it. How do we get more resources to invest in economic growth?

Al Charbonneau: We really need to think about where the increases in premium are coming from, and we need to avoid pieces that are waste.

Paco Trilla: Just briefly, I think one of RI's advantages in our infrastructure has a healthier network of primary-care providers, specialists, etc. than some of our neighboring states.

Ted Almon: I can comment on that as my father was on the Health Services Council. If you can restrict need then can reduce expenditures. That process means there needs to be a plan, to approve or deny requests as come in. The second is that it has to be a-political. The theory of CON is good.

Secretary Roberts: There was a new law passed 15 months ago, the newly formed Health Services Council will meet in a few weeks. It is a smaller group with specific members with terms, and it should function differently. Here is my challenge around the plan - I don't want a plan that is anchored in the historical trend use. I want a plan that sees where we want to go and where we want to be, putting together many components.

Lou Giancola: Affordability was a standard, but it was the ability to support it, not the affordability of the system. A concern about the comment of excluding some expenditures from the cap. For years we have been complaining that the health care system gets saddled with many social needs. I don't know if that is accurate, but it is something we lament about. We should be looking at social costs as we look at health care expenditures. Also, mandates - I believe we tend to have a few more mandates than other states.

Elizabeth Lange: The reconvening of the health services council was great, and I know from testifying before a committee important to identify why something is important, why something is not and encourage us to think about that when considering CON and the health services council.

- III. Public Comment – No additional comment was offered from the public at this time.
- IV. Adjourn – Meeting adjourned. Next session 10/27