

Spending Cap Subgroup
Tuesday October 27, 2015
Meeting Minutes

- I. Welcome – Secretary Roberts
Secretary Roberts welcomes the group to this morning meeting, thanks everyone for coming and turns over to Cory King to begin the work of the day.

- II. Total Cost of Care Report – Cory King with the Office of the Health Insurance Commissioner

Mr. King presents on the Total Cost of Care Report which was commissioned by the General Assembly back in 2013 to take three years of claims data and calculate the per capita medical spend, and how did it change over that period, and how does that trend information look. A final report will be released on November 18. Preliminary data will be discussed today in a presentation.

Presentation slides available upon request via email to lauren.lapolla@ohhs.ri.gov

Questions during presentation:

Ted Almon: The PBN changes appear transitory at best, shouldn't we take it out?

Cory King: Someone did ask the actuaries if they could do it and still present so that there was no generic launch. I will have to go back and verify if they found that feasible or not.

Mark Montella: How does this data reflect import/export claims data?

Cory King: The RI data is based on residency, so if you went to Massachusetts your claims are in here, and if a Massachusetts resident found care in RI their claims would be in RI. That was the purpose to focus on, total cost of care for RI residents, but yes good question in import/export claims database.

Al Charbonneau: Outpatient, is that outpatient hospital or all outpatient?

Cory King: All out patient – hospital owned and free standing.

Secretary Roberts: What is MHCD as referenced on the Commercial Benchmarking Slide?

Dr. Hittner: Mental Health & Chemical Dependency

Lou Giancola: Is the maternity utilization trending higher?

Cory King: Yes it is saying that, over the three years the utilization trending was up.

Sam Salganik: It looks as if you add up observation and Emergency Room we are about the same as Massachusetts (On the Commercial Benchmarking Outpatient facility slide).

Cory King: Right.

Mark Montella: Challenges in looking at this database how it is being filtered in some ways.

This is just the commercial book of business, and the impact of policy from the federal government has an impact on commercial side too. It is understandable why all of a sudden the move to outpatient grows, for example, when considering new federal policy on treatment of schizophrenics. When looking at the commercial book it is being influenced on policy outside its own sphere.

Secretary Roberts: To clarify, this data this morning is in fact commercial. Overall (including Medicaid and Medicare) the trends are very similar to this work.

Cory King: The majority of the data is from RI claims data so we will have information in state. We can only get comparison data on the commercial side.

Elizabeth Lange: It would be helpful to understand how these categories are put together. It used to be if something was called an outpatient facility it was lower cost, but often facilities now tack on other areas, which may make them look more like inpatient.

Cory King: Good point, absolutely.

Al Kurose: One of the things we have learned over time in our work at coastal is that focusing on trend drivers is not always what you want to do. Want to look at what is actionable; the difference in our utilization patterns vs other states – if that hasn't changed much in a few years it is not a trend driver. Looking at how we vary at the absolute price or utilization level not just in terms of trend changes, the absolutely price level with other neighboring state, may help us come away with half a dozen things that we want to look at.

Cory King: You bring up a great point that this Working Group may want to look at what factors support the level of medical spend in RI, and decide between which factors are endogenous or not; what is outside of our control.

Al Kurose: Right, so it makes me think maybe we exclude some items from our conversations and we work on things we can impact.

Paco Trilla: On pharmacy, it may be something we cannot change. A lot of this is cost shifting at this point, and copayments, certainly there are efforts in other states, legislative efforts, local efforts to help raise awareness of the issues. This really isn't exogenous. We cannot control it directly, but it is a huge cost

III. Discussion

Mark Montella: I think that if you look at the Massachusetts experience on biologics, it is crushing. We can say we do something about it, biologics come on and treat that which was once untreatable. Do we say we will not spend there? It is hard to tease it out, it cannot be ignored, but rather you need to think about how you deal with it.

Al Charbonneau: I was at a meeting with FM Global and they introduced themselves by saying that they are an insurance company, but they do not hire actuaries, they hire engineers. Reason being engineers try to solve something so it does not happen, whereas actuaries fix something that has already happened. I would argue that we should start to look at expenses if we are going to control the cost of care, and understand how those

expenses impact that.

Ted Almon: I am trying to think through how to link this to the spending cap. I find myself enormously frustrated by thinking about how this would work, given it would need to be retrospective. It is incredibly difficult to measure, but how do you allocate blame or responsibility throughout the group. It strikes me that spending cap is nothing more than a retrospective form of rate setting. Why not set the rates up front? Why not define what we think is affordable, set the rates on premiums and let the providers figure out how to spend the money?

Secretary Roberts: It is one reason for this [Total Cost of Care] report: we didn't know how much we spent and what we need to spend. Many would argue what we spend is already 25% higher than what we can afford. Some of it is how do we move from where we are to where we want to be. This is the interesting conversation, business may say they want to reduce that 25%, and they are doing that now with cost shifting on the industry side. I do not think there is anyone in our world who would be willing to do that, thus manage the trend instead.

Mark Montella: The fixed cost is still sitting there, but the as the variable cost moved, unit costs go up. Here in RI sometimes I feel we are chasing Massachusetts, and perhaps they should chase us. If your economy is growing faster, you can spend more. If it is not, you can spend less. There is enormous venture capital flowing into Boston, more than NYC. Real estate in Boston is so high, rents are sky rocketing. People don't stop going into Boston to spend more on medical care. Look at how much you utilize based upon the size of your economy. Massachusetts' economics are different than ours, the populations are different than ours. If you look at providers in Massachusetts, you may rather practice there because you get paid more.

Secretary Roberts: Let's be clear, we do talk about Massachusetts a lot. They are not the only state doing this; their goals are fairly comparable. Many states are thinking about how to manage the cost escalation system. Maryland has a rate setting structure. Massachusetts has it on the economic forecasting side. So if you are thinking about managing the cost of care, what is the basis upon which you do it? Looking backward, overall inflation how do we think about it. In looking retrospectively vs prospectively where do you see the differences?

Sam Salganik: I think that being able to work prospectively would be amazing. Even now we are looking at 2013 data, and rates are being set now for 2016. I don't think that we have built the necessary infrastructure yet to do prospective rate setting in the right way. Maybe that is where we go.

Joe Iannoni: All the data is FFS provider data, no correlation to premiums, reserves, what happens is some of this doesn't reflect shared savings plan or risks. Make sure when we get a defined path that we are trying to develop a cap and worry that if we are looking at hospital stays, or FFS only, we do not look to what say self-ensured employers do. Don't

want to solve the wrong problem.

Al Kurose: Is there a reconciliation at some point with rates and premiums? If there is money year after year do you keep it, or give it back to the consumer? We should include in all of this some kind of a link to premium.

Secretary Roberts: The federal law does that through medical loss ratio, saying medical loss ratio cannot be less than a certain amount. At what point do you dial back.

Al Kurose: I would have to understand better within the medical loss ratio how consumers are protected or guaranteed. Isn't premium relief some of our goal here? If the limit to our system is that it is retrospective, than can we look at having retrospective relief? We are constantly talking about spend, but we only occasionally talk about that premium relief should be some of our goal.

Mark Montella: If we step back for a moment, we once had prospective rates for the hospital. The state and BlueCross BlueShield (BCBS) would set it, and that ended in 1991. I think the question is what kind of a system do we want, and how do we create a regulatory system that supports that? RI used to have an infrastructure that was aging out. RI was also the last state in the union to have MRI unit built in one location. Rates were stable, but what happened on the delivery system; when you decouple them, you had infrastructure that aged out badly. If we are going to go back to it, we should think about the template for why it failed and why we left it. I feel we are going back to where we began.

Secretary Roberts: Why did we get off the system?

Mark Montella: I represented physicians back in the 1980s, and they were severely disadvantaged by the idea that their profiles were frozen by what BCBS had decided in the day, and that is what Medicare payed them. Think about how technology gets deployed,

Secretary Roberts: This will be an evolutionary process no matter where we are going, say that we need to manage cost overall, and then within those structures, within the industry, talk about where should we invest and what do we invest. Al, in Rochester did they do it proportionally?

Al Charbonneau: Basically it was a revenue cap, and went from an FFS model to a non FFS model in '79 that was implemented in six months. We moved to a market basket approach, develop trend factor based on the premise that if you could not control something – i.e. natural gas – then you were paid for that. If you could – wages, overhead – then the trend was set by a market basket and you were asked to work with that. You call it a cap, you call it a market basket, not that different, but it is different than what I understand Maryland's model to be. I think the important difference is that part of the Hospital Experimental Payment Program (HEP) experiment was to provide leadership to the hospitals, get us in a room, and bring to the table the best ideas we could to also get to what the population wanted which was lower premiums. Two doctors in the room raised the level of discussion, two administrators, etc. What the HEP Experiment it did was focus the hospital CEOS and hospitals with reaching those goals. That to me is dramatically different than the Maryland model.

Al Kurose: Was it not part of the Rochester experiment that when the hospitals came together and had these budgets to manage, that some hospitals would negotiate and offer some services, and others not.

Al Charbonneau: Yes, if we had not done the HEP experiment we would have spent about 3, 4 billion dollars more (which in that system was about 3-5%). I don't think the hospital system is efficiently managed – it is well managed, but not efficiently. For those of you who want to talk about value, we are buying more and more value. We wouldn't have driven to conclusions without staff and hospital trustees working together. I feel that is missing here. My argument would be that with respect to the state of RI, RI is about the same as Rochester. If you can do something, put from insurers point of view, stability and rates.

Secretary Roberts: A big difference is that hospital inpatient is a driver, but not as much as it was in the 70s and 80s.

Al Charbonneau: The other point I look at most of what I see, the incentives were so small that it doesn't imply this will be meaningful. One of the experiences with the HEP experiment was that discharges went down. If we could take a case normally seen on inpatient and move it to outpatient, you can save significantly. It moved those patients out. The second thing, once we establish that budget that amount was divided by the federal government, by Medicaid by BCBS, and we received a check at the hospital each week, had that revenue taken care of each week. The Advisory board makes the point that it is difficult to have a foot in two boats, staging over four years is difficult. The HEP experiment took care of that by saying that an allotted percentage of revenue was taken care of. We have an opportunity, a million people give or take, look and see what it needs to take care of these people. What Don Berwick was talking about the other day is thinking about what you want to take care of.

Secretary Roberts: Think about how to drive inputs, drive costs to improve population health. To me what is interesting about considering this is, what is the market basket that you then ask the different participants in the market.

Joe Iannoni: The CAP cannot be just hospital only.

Secretary Roberts: We have a current hospital cap structure, but this an industry wide program.

Joe Iannoni: I do not think we will come up with anything better than what Massachusetts has, what is included in the cap, wrap in the health insurance premium piece.

IV. Public Comment – No additional comment was offered by the public at this time.

V. Adjourn – next meeting of this subgroup November 10 7:30am