State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
May 16, 2017, 4:30 P.M. to 6:00 P.M.
Blackstone Valley Community Health Care
39 East Avenue
Pawtucket, RI

Attendance

Members

Co-Chair Commissioner Kathleen Hittner, Al Charbonneau, Sam Salganik, Karl Brother, David Feeney, Lisa Tomasso, David Katseff

Issuers

Megan Dennan, Blue Cross & Blue Shield of RI
Emily Colton, Neighborhood Health Plan of RI
Lauren Conway, United Healthcare

State of Rhode Island Office of the Health Insurance Commissioner Staff

Jay Garrett, Cory King

Not in Attendance

Co-Chair Steve Boyle, Howard Dulude, Gregory Allen, Bill Schmiedeknect, Tammy Lederer, Pat Mattingly, Hub Brennan, Vivian Weisman, Ruth Feder

Minutes

1. Welcome and Review of April Meeting Minutes

Commissioner Hittner called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance.

The minutes from the April 18, 2017 HIAC meeting were accepted unanimously with no changes.

2. Introduction of Council Members and OHIC Staff

This HIAC meeting served as the Office's Quarterly Public Comment session. For the benefit of the members of the public in attendance, council members and OHIC staff each introduced themselves and gave a brief description of their role.

3. Overview of OHIC's Mission, Duties and Responsibilities

OHIC staff member Cory King joined Mark Gray, Health Policy Analyst with DataSpark, in delivering a presentation to the public on the mission, duties, and responsibilities of the Office of the Health Insurance Commissioner. The presentation was introductory in nature, focusing on OHIC's four major areas of work: consumer protection; laws, regulations and enforcement; health plan form and rate review; and healthcare reform and policy.

4. RIREACH Consumer Update

Sam Salganik from RIREACH explained that RIREACH, a program of the nonprofit Rhode Island Parent Information Network (RIPIN), is OHIC's consumer assistance partner. The RIREACH call center assists approximately 3000 consumers each year. In April, RIREACH handled approximately 200 calls.

RIREACH is able to help consumers with issues relating to both commercial and public insurance. Top consumer issues recently include difficulty enrolling or renewing enrollment in Medicaid due to technical problems with the state's new UHIP computer system; and consumers facing surprise medical bills from providers that they did not know were outside of their health plan's network.

5. Health Reform Update: State Innovation Model

Commissioner Hittner spoke about the State Innovation Model (SIM) project, a $20 million grant for healthcare system transformation. The Commissioner explained that this grant is not funds solely for OHIC but rather for a multitude of state health agencies. State agencies like OHIC, EOHHS, HealthSource RI and others are working together and with community partners. The SIM project is focused on enhancing primary care, improving public health through community health teams and other methods, and transforming health care payment methodologies and delivery systems.

6. 2017 Legislative Session Update

An article in Governor Raimondo's proposed FY18 budget would move utilization review responsibilities from the state Department of Health to OHIC. Commissioner Hittner explained that OHIC is already responsible for following federal utilization review regulations and forms and that moving all utilization review responsibilities from DOH to OHIC would be more efficient.

Sam Salganik commented that there are multiple bills in the state legislature attempting to address the problem of consumers receiving surprise medical bills. He said RIPIN is supportive of these efforts but the bills that have been introduced have different approaches to the problem.

Lisa Tomasso reported that a bill has been heard that would include community mental health organizations as a provider subject to prompt payment rules. Mental and behavioral health providers had previously been excluded.

7. Commissioner's Remarks

Commissioner Hittner reported on agreements reached with all of Rhode Island's major commercial insurance carriers to discontinue the practice of requiring prior authorization for coverage of certain medications used to treat opioid dependence disorder.

The Commissioner also took the opportunity to update the council and members of the public on the health insurance form and rate review process. Carriers have filed large group rate requests for 2018:

2018 Large Group Rate Requests
BCBSRI - 11.9% increase
UHC - 10.3% increase
Tufts - HMO 9.8% increase
Tufts PPO - 10.4% increase

Cory King commented that this year's requests were substantially higher than last year's.

Rate filings for the Individual and Small Group markets are due June 16. A public input session will be held mid-July. OHIC hopes to have final rates approved by August 1.

8. Public Comment

Note: This HIAC meeting also served as OHIC's quarterly public input session and therefore had more allotted for public comment. A lightly edited transcript of the public comment portion of the meeting is attached to these minutes.

Next Meeting

The next meeting of the Health Insurance Advisory Council will be Tuesday, June 27, 2017 from 4:30 P.M. to 6:00 P.M. at the State of Rhode Island Department of Labor and Training, 1511 Pontiac Avenue, Building 73-1, Cranston, RI 02920-4407.

Transcript of Public Comment

Health Insurance Advisory Council / OHIC Quarterly Public Meeting

May 16, 2017

Stefan Ward-Smith, NFP Health, HealthsourceRI SHOP: Large group typically implements wellness programs in Rhode Island attempting to keep costs down, in some way. If you participate, your premium is reduced… anything like that sort of possible for the small group?

Dr. Kathleen Hittner, **Health Insurance Commissioner**: We talked about that as a Committee. We had one of our members present what they do at Lifespan. --- Wellness… they don't hire smokers, the have a lot of things they do to help their employees stay healthy. So what we're trying to do is the Patient Centered Medical Home to work on all the citizenry, not just individual groups. But I don't know how you go about going that, it's a very good point. I don't know. Unless things change… I don't know how you would do it

Cory King, OHIC: I think it also interacts with Community Rating requirements in the small group market. So it just is something you don't really see. You see a lot of self-insured groups doing that kind of thing. We were just talking about the Large Group Market, well, self-insured market, even larger than the fully-insured Large Group market, tends to see much lower health care costs. Larger groups, the risk pool isn't as fractured, the plan administrators have much more flexibility.

David Chenevert, Executive Director, RI Manufacturers Association: I am just curious what the advisory council and Commissioner's office is doing for sole proprietors who are in the manufacturing sector, and they have 3 or 4 employees, they're a corporation, but because the employees are not taking health care, that sole proprietor is being thrown into the single group vs. the small group. And I believe right now many of our members who are in that situation are getting the short end of the stick. And I just want to know what the advisory council and your office itself is gonna do about it.

King: I think it's a matter of Federal law…

Chenevert: No, it's a state law.

Melissa Travis, HealthSource RI SHOP: So we filed, um, we did file a.. cause we know there's a section 1332 waiver process that needs to happen so we did file H6082, it was actually filed in the House… We've had almost 5000 complaints from small business, between the National Federation of Independent Businesses, the SBA, SBANE, uh… and I know many of our members, and what we didn't realize [and what the RI] society of CPAs has helped me understand is from a tax standpoint, it's been really hurtful for a lot of these corporations that have funded their FSA or HSA plans where it's actually tax-prohibitive to do that now. So we don't know what's gonna happen because I know Senator Miller was trying to put it on the S0831 bill, I think he was going to try to do something like that but they don't

know what's happening with that. So I don't know what's going to happen to the legislation… we've heard a lot about that too.

Sam Salganik, RIPIN, HIAC member: I'll comment wearing a slightly different hat. I used to be legal counsel at HealthSource in 2013, when the new federal laws were going into place from Obamacare. It was a matter of federal regulation that required the sole proprietors, the groups of one, to go into the individual market. We were able in 2014, working with OHIC, to sort of delay, and we pushed it off a year. It may be that through a section 1332 federal waiver that you could waive that federal requirement…

Dr. Hittner: But it is a federal requirement?

Salganik: It was a federal… when we looked at, I haven't looked into the regs in a couple of years. A few years ago it was a federal requirement.

Dr. Hittner: That's how I understood it.

Salganik: And.. but as you say, it may be possible through Section 1332 of the Affordable Care Act to waive that federal requirement, if the state wants to.

Travis: So, my question would be, if these don't… because I know, we know the fun of the General Assembly and what happens in the House and Senate, is it something that the insurance commissioner's office could seek the waiver without legislation? I mean, because all of the business groups – we actually had all of the business groups, Rhode Island Business Coalition, RIPAC, every single organization in the state, probably for the first time ever, came to agree on this bill, as written, because it's hurt so many small business owners. Is it possible that the insurance commissioner's office could take a stand on this without legislation? Because, like I said, I know getting something passed through the House and Senate… It could be easier…

Salganik: If I'm not mistaken, there was a bill a year or two ago that gave authority to, I don't remember which office, but it was EOHHS or OHIC or HealthSource or some combination, to seek a 1332 waiver…

Travis: It did it's actually in budget article 18.

Salganik: Yeah, I don't remember if that was time-limited authority or not…

King: Yeah it's something we can study I think?

Dr. Hittner: Yes.

King: Take a look at it. On the other hand of it, too, you have to also think, as the regulator, we have to think what happens to the individual market now that you're taking lives out of it, and you have a narrower risk pool there.

Ralph Coppola, SBANE: Yeah but, as a business person, you gotta think, why are you taking away the tax advantage of the deductibility of health care to me, as an independent business person. So, ultimately,

are we a small business state or are we, uh, what are we worried about? I mean we have to worry about small businesses in this state because they're the lifeblood of the state.

Travis: I think…

Coppola: And if we start doing stuff like this to the small business community, they just move to Massachusetts, which, a lot of times they do anyway, unfortunately, so…

Dr. Hittner: Are you talking about the same issue…?

Coppola: Yes

Travis: Actually, one of the questions…

Coppola: Yes

Hittner [aside]: well I don't know that Massachusetts has it any different…

Travis: Mark Heyward… Massachusetts, yeah

Coppola: They combined it.

Travis: They actually have a combined…

[cross-talk]

Travis: … they didn't have to do it, because their market is the same for individual and small group. It's one market, they did that a few years ago. One question, Mark Heyward made a good point, and he wanted me to ask this question on behalf of the SBA. He said that because it just changed - because that's what he had heard too, someone said that to him, "well what happens to the market and blah blah blah," this just changed, it's only been the past year. So it's not like, I mean, historically this has been the case, these businesses were able to go to the small group market. The S-corps, the self-employeds and the sole props. So it's only been one year, so it's not like we don't have that history. If anything, it's only been one year, so the sooner we do this, the sooner we can revert back to what we already know and what these business owners know. In addition, in Rhode Island, as you know, brokers don't get individual commissions. What we've seen, we have a very aged workforce, so we have a lot of business owners, I have had women that call me crying, older women, older men, and they say "I had a broker my whole life and now I can't get assistance." And I can't blame them, I mean, they're no longer paid for that. But you're sending somebody to a market they are unfamiliar with, their entire life they had commercial insurance, there are tax implications, that's why the society of CPAs got involved, so there's a lot of things but it's only been one year they've been forced to the individual market. So we have the data, y'know what I'm saying? We don't have to do it, it's not a heavy lift to say, "let's just revert back," we already know it's only been one year that we've been like this and I think Mark made a really good point with that.

Dr. Hittner: Ok, we will look at it, we will study it, we will see if there something we can do.

Salganik: I'll add another twist, not to pile on, we got a bunch of calls actually in our call center from folks who had been in the small group market and were forced to transition. The big issue that we saw – obviously, federal law it was federal law, we couldn't help people get around that – but one issue that we saw was that, in the small group market you renew on an annual basis based on when you bought. So some people are March to March, some people August to August. And in the individual market everything is January 1st to December 31st. So in terms of deductibles, what would happen is someone would, say, their small group plan ended August 31st. They would buy an individual plan September 1st, but they had the full year deductible applied, even though they were only going to have the plan for four months. And then they would start again January 1st with a full year deductible. So one thing that, maybe, would be possible if this eve.r happens again is just to think about probably through some kind of an instruction from OHIC there might be the authority to in, certain situations, to require plans to pro-rate deductibles, or things like that, when people are forced to buy a partial year plan. Just a thought.

Travis: The Rhode Island Society of CPAs said that, and that's one of the points why they jumped on, because they had, they showed us several things that business owners can do that's not necessarily on a calendar year so their renewal of health insurance may have just been one piece of the major package they had in place, with benefits for, y'know, all kinds of different things that was maybe April to March 31st, and now everything is kind of upside down, so… um, but the deductibles resetting, and we actually still have customers that are going through that this year as they age out, y'know…

King: As the Commissioner said, we will put this on our task list to evaluate. And I think if you're gonna, if you find an administration is willing to grant flexibility to the states, it's the administration that we have in place now. At the same time I would also encourage folks to think about novel and innovative approaches to stabilize the individual market, because that is only going to get worse. Particularly if health reform goes through, and people have a smaller tax credit to purchase insurance. So, whether its creating a state-based reinsurance program or something like that. I think at the same time, we need to consider that market as well.

Karl Brother, former business owner, HIAC Member: Today is the 16th of May. The legislature is going to finish their work, hopefully in less than a month. And if there's a bill that's already pending, can we put this on the front burner to review the bill and see whether it's something the Insurance Commissioner should support, for this year not next year?

Dr. Hittner: Ok.

Brother: Thank you.

Al Charbonneau, **RIBGH, HIAC Member**: Is it in 831, is that what you said?

Salganik: I don't think it got into 831…

Travis: House bill 6082… and the Senate bill that Senator Miller wanted to put it on a sub-amendment was S0831.

Salganik: But it's not in the current 831?

Travis: It's not in the current 831 anywhere and that's why we were…

[cross-talk]

Charbonneau: Is that going to be amended? Have you heard of an amendment coming?

Salganik: I have not heard of an amendment coming. But I… given that it was released late, and that a lot of people are pushing for something like it to go through, I would imagine that if it goes through there would be some amended version that would get… that goes through. I'm guessing. But it's a pretty complicated piece of legislation.

Charbonneau: 71 pages!

Salganik: So I would imagine that there would be some people who brought forth comments that they would want to respond to before they passed it.

King: That's the market stabilization bill, Sam?

Salganik: Yeah.

Dr. Hittner: Ok.. yes?

Chenevert: Just speaking for the 1600 manufacturers in this state, I urge commission to try to get involved in this as quickly as possible. There's a lot of small businesses that are really hurting on this and I'd really appreciate it that you could use your influence relative to H6082, and on the Senate side.

Dr. Hittner: Ok, thank you.

Jacob Brier, Small Business Owner: Just wanted to give a little background about health insurance costs at our company, and then two things I'd like to say, and a series of questions that came up…

Jacob Brier from MojoTech, a software development agency. We have up to three people. We purchase insurance through the exchange. Salary and payroll taxes are the two largest items on our budget. Of everything else remaining, about 50% of it is health insurance. We offer 100% coverage for the employee and they pay for any dependents. And that's what we've done since the company hired its first employee. And that about 50% has gone up each year. It's always been a larger and larger share. We've had various insurance plans, but it's taking up a bigger and bigger chunk of expenses. What I'd like to see is the exchange for businesses be treated as a large group. It's bringing thousands of companies – or, at least, hundreds of companies, thousands of lives into one group where people can select their plan. So why can't that be treated as a large group, like it is one company with 5,000 people? Because it is still expanding the market, still diffusing the risk, just like a single company would. And that would lower costs. What I'd also like to see is more access, user-friendly access, to the information that is publicly available, but really hard to consume. It's really hard for people to um… it's very easy to get information out nowadays, so that could be more public. I think if people understand what goes into the cost increases and what drives it, it's easier to make those decisions or to advocate better on their behalf. So I'll go right to the questions now. The first one was related to data. In the narrowing of the

variance between what carriers requested and what the Office has approved. What drove that to narrow, and is there data to support that it's because insurance companies are getting better at lowering their costs, so that they're not asking for as large of an increase – or is it simply, these two sides have been negotiating for a while and so now, one side comes up a little and the other side comes down and so it's just trending closer? Or is it trending better? Is there data support that?

King: I think you are referring to that chart we showed earlier…. The last couple of years the rate requests from the health plans have come in a bit lower than they have historically, and I think there are a number of reasons for why that is. One is, I think some of the initiatives this office promotes are having a marginal impact, I'm not saying that's the whole picture. Part of it too, is there was still a lag in the uptick of increased utilization after the recession, so people were still using healthcare services at a lower rate, particularly inpatient hospital services. That's continued and helped hold claims trends down. I think the other thing is, too, is we've had a fairly stable market over the last few years, particularly since the aca was implemented, so there hadn't been wide swings in the risk pool. So probably a mixture of things. Now, as I just told you around large group and as we expect for small and individual, I think those rate requests are going to be higher….

[cross-talk]

King: I'll also refer you all back to the first slide on our statutory mandate. Commissioner Hittner has a very unenviable job ahead of her, because she has to, at the same time, focus really hard on the affordability of the insurance product, but she also has to ensure that the insurers have adequate premiums to cover costs, and to ensure they're solvent. That's a difficult balancing act, particularly in some cases.

Dr. Hittner: So I would say, one of the things, when I go to meetings of other insurance commissioners around the country, our rates have been more stable than most of theirs. And if you look at the literature, some of their small groups have gone up 30% a year, 20% a year. Ours have been more stable, and part of that, frankly, has to do with the fact that Rhode Island had a lot of mandates that the Affordable Care Act put into place, before the Affordable Care Act… so we had time to sort of build this into our rates – the age 26 for the students, pre-existing conditions – that kind of thing was already in our rates. And it will be there if those things go away in the ACA because it's in our state regulations. But because we had to bring that in sooner, our rates adjusted a little better to the ACA than others. I feel that – and I don't want to speak for the insurers, this is my speculation – part of the rates reflect extreme concern and uncertainty with what's going to happen at the national level. And one of the things I've talked to my team about was, that's what we also have to look at in the rate requests this year, how much of that is that concern, and if it is, can we say to them, let's do these rates based on what we know now. If something happens that's going to have a big negative influence, maybe we can re-open the discussion. We have so much going on right now that's causing confusion, fear, uncertainty, that we're going to be very busy this year trying to play an important role for all of you.

Brier: The rate increase that's mandated for hospitals and ACOs, capped at 1% above CPI – if that's able to be mandated, why would that not tie to rate increases from the insurance companies? So if a hospital

can only charge X more than last year, why can insurance companies charge even more than that to consumers?

Dr. Hittner: Because although hospitals are a big driver, there are other big drivers of expense, such as pharmacy - which has gone up dramatically – utilization, those things. We can control the rate to pay for an open-heart surgery, but we can't control how many open-heart surgeries are done. So for the insurance companies, there are other things that influence the rates they seek, and what we have to do is we have to look at their reserves, and we have to say, they've got enough reserves to pay all of the bills that are coming in if everything goes to hell in a hand basket. There's defined measurements we take to look at that, and then we have to see how much they need to put in reserves each year to keep up with that. It's extremely complicated, and people do think, "well, you shouldn't let them charge so much. They're making a lot of money." Well, they're not. We look at what they're making, we get some controls on that, as to how much they can put into reserves and things of that nature.

Brother: The steps associated with rate review, and the kinds of information and data that you look at are pretty well defined?

Dr. Hittner: Yes.

Brother: Speculation about the state of the world in 2018 is not part of that rate review process. So, if somebody comes in and is asking for an 11% increase, they need to show those various elements of the formula… how are they justifying an 11% increase. And if it's not there, then you will this year, as you have in the past, come to some point where that's unacceptable, and here's why we think it should be 4%, not 11%. It's not an arbitrary process.

Dr. Hittner: No, that's right. We look at, say, their assumptions on inpatient utilization. And if they say, "inpatient utilization is going to go up by 10%," we may say, "no way inpatient utilization is going to go up by 10%," or whatever. Al, you had a comment.

Charbonneau: I just want to say that one of the things that the insurers had said to me, not as a HIAC member but just as we [indecipherable] and the affordability standards, that cap has given them some degree of predictability in at least fifty cents on the dollar, which is what the hospital costs are. However – and that started, what, in 2010 or 2011?

King: 2010.

Charbonneau: But we really can't rest on our laurels, because it turns out that our hospital costs are like the fifth or sixth most expensive in the country. According to Blue Cross, our family plan is about 10th or 11th most expensive. According to the Commonwealth fund, in 2006 a family plan was roughly 16% of median family income, and by 2015 it was 22% of median family income. As a former hospital CEO, but now working on the business side of things, I would say that the business community really needs to be pushing down on organizations that are trying to move these items forward. We have plenty of excess capacity in the hospital world which is very expensive. When we look at our behavioral health costs, they're the most expensive in the country. The National Safety Council just produced an opioid

calculator to figure out how much it costs you to treat opioid patients. So I just ran a 250 employee business in Rhode Island – turns out, we're the most expensive for opioids. We have a large cadre of behavioral health providers that are not part of networks, and that's considered to be the wild wild west of pricing. So there's plenty of things that can be done. In fact, my argument, as I look at premiums… the buckets that I see are delivery system costs, insurer costs, and taxes and assessments. And if you look at the five years during the ACA, the big ticket items, number one is delivery system costs; number two, taxes and assessments; number three, on the insurance side, it's miniscule. So the arguments that you're hearing today in terms of controlling insurance expenses, at least so they're not going up disproportionately, probably are working. But that's still the small end of the pie. The big end of the pie is what we find in the delivery system. And as we think about population based health, we really need to be putting on the table how many hospitals do we need, how many services do we need.

Keith Demty, Health Insurance Broker: I agree with what you just said, Al, it's the delivery of services that's really driving all the costs. Within that, you mention hospital expenses but right now the biggest driver – and the Commissioner has put some controls in place, as you mentioned, to try to control that on a going forward basis – right now the biggest driver of the total health care expenditure are prescription drugs. Prescription drugs, fifteen years ago, was maybe 15% of your overall premium. It's not about 26, 27% of your total premium. I guess, my suggestion is, as the Commissioner put on other lines of businesses like hospital, patient-centered medical homes, is there a way to focus on prescription drug expenses, which really have been the primary driver the last couple years.

David Feeney, Pharmacist, HIAC member: Admittedly, the price of drugs is going crazy. I've owned a community pharmacy for 43 years…. That takes a federal action to limit the cost increases… The cost of drugs, you think they're bad now? Some of these new drugs that are coming out, these new treatments? They're astronomical.

Demty: We should have federal price controls…

Feeney: A lot of people in the room think the same thing. However… In the meantime, what the health commissioner has done and what we, a little over two years ago, presented to the committee was what pharmacy is doing to help limit cost increases or reduction of cost, through different programs or whatever else. The health insurers – I keep saying, don't beat up the health insurers because of the cost of drug increase and what that does to the overall increase of the insurance costs – it's the manufacturers. They have gone through and instituted a whole bunch of programs to help reduce the utilization – over-utilization, misutilization of drugs – and the physicians' practices, Coastal Medical and some of the other big practices, patient-centered medical home offices, they've looked at that, they've looked at transitional care, going from emergency rooms back to the community, from skilled nursing facilities, rehab facilities back to the community, what those costs are. There are a bunch of programs the insurers have been out in the forefront, across the country, to help reduce the cost of drugs to the overall plan. There's some good things that are going on…

Demty: Here in Rhode Island, drug trends are in the double digits. They're in the teens.

Feeney: Right, but, once again, there are some programs in place to help keep those costs down. Does more need to be done? Absolutely. Some of the programs that are out there, I'm not too sure how effective they're going to be, we'll have to see. But these things are being done to do that…. Biggest of all things is the price. How do you control the price of what it costs for that one dosage unit? [cross-talk] You go from a dollar capsule to $300 a capsule overnight…. And, believe me, as a guy that used to have to write the checks and pay for those bills, you know…

Demty: And so I'm asking, is there a way the commissioner could regulate those sorts of exact situations? An overnight price change from a dollar to $300?

Feeney: Oh, that's… I think that's above everybody's paygrade.

Dr. Hittner: What we do try to do, and we're looking at even making it a little more tight, is notification of patients. Because they get notified, what is it, Jay, 30 days now?

Jay Garett, OHIC Staff: 30 days in advance.

Dr. Hittner: …if their drug is changed. And I was recently at a meeting of a group of nonprofits that deal with patients with chronic diseases. And that was their biggest thing – drugs change too often. And these patients that have diseases are set, they're doing well on a drug, and then they change the formulary. So we would like to do something to give even more notice than 30 days, and to try to limit how often during the course of a year they can change the formulary. That is, I think, something we could do. It will take a lot of effort. But as to the cost, I don't know how, legally, we could do that. I don't know.

Brother: Are any of the new biologics part of the drug costs?

Feeney: Well it's starting to be part of the drug costs. It's going to be a bigger percent over the next two, three, four years.

Brother: As companies develop – relatively small numbers of people with this disease, they develop a drug for that, and price it out at $80,000 a year, that's the kind of thing that will drive prices up.

Feeney: Sure, yeah. And even the biosimilars – that's another name, a technical name for a generic of a biologic – generic prices from the brand name, there's usually a big differential. But with biologics and those biosimilars, that differential is not as big. So you're talking $80,000 down to $60,000, for example. That's $20,000 difference but you're still talking $60,000 a year to treat one patient as opposed to, maybe, $3,600 for some of the others. Just as an example. Do all of these things have to be looked at? Yeah. Have operations like Al has with the Business Group on Health and some of the health insurers and everything else, everyone's looking at it. How do you deal with it? And that's been going on for a number of years. It's all going to have to play out, again, I think, on the national level.

Brother: Is it at the national level because that's what the ACA calls for? Medicare doesn't get involved?

Feeney: How do you limit what the government says is fair market price? Manufacturer can charge whatever they want.

Brother: So, but that's the point I'm making…

Coppola: The feds aren't allowed to negotiate, Karl. The feds are not allowed to negotiate prices with the drug companies under part D of Medicare. Recently, though, the Veterans Administration is and the price of the pharmaceuticals at the Veterans Administration are 22 times less than the Medicare price.

Robert Dumet: I'd like to also suggest a little more flexibility from the carriers in terms of the ability to carve out drug coverage and shop the marketplace. I mean, there's a lot of PBMs out there, Blue Cross has picked one, United has picked one, but there's other options.

Dr. Hittner: Are you saying that they should give patients the option….?

Dumet: I'm saying the carriers should let larger employer groups have the ability to shop the marketplace and maybe find a better deal.

Travis: Actually, can I ask a question? Thank you for reminding me, we get that question all the time from our clients, and I have no idea. When the carriers announce that they're switching, is that a review process that's a transparent process? Are you included when they say, "ok, we're going to switch pharmacy benefit managers," or whatever?

Dr. Hittner: No, they can switch pharmacy benefits… We're more into the notification, and to make sure that there's adequacy as to what's in the formulary.

Garrett: Yeah, that actually falls under the purview of the Department of Health. If there's a change in the utilization review by the health plan, they have to get approval from the Department of Health prior to implementation. Part of that process is appropriate notification to patients and providers before it's implemented. What we found out over the years whenever there's a change in PBMs for example, there's often issues with claims systems and things like that. People that are on a prescription drug for years and then there's a change and all of the sudden they go to the pharmacist only to find out they have to go through step therapy because there's a new pharmacy benefit manager. There's a lot of bugs that need to be ironed out in the process.

Lisa Tomasso, Providence Center, HIAC Member: So will that follow utilization review to OHIC if that legislation is passed?

Garrett: Yes.

David Katseff, small business owner, HIAC member: Can I switch subjects just a little bit?

Dr. Hittner: Sure.

Katseff: Going back to rate review… right around this time last year it was announced that Blue Cross reduced the rates to the small business market by approximately 5 or 6%, which was supposedly to

account for that 2016 claims came in much lower than was anticipated. So that was reflected for small business who got new packages after July 1, they got a substantial reduction in the rate for 2016. For small businesses like my own that had to wait until January 1, supposedly we got a substantial reduction than what 2017 rates should have been. So, I'm leading up to: If this only happened a year ago, how could things so drastically change, going from announcing a 5% rate reduction a year ago to announcing rate increases, for January 1, to 12, 14%? The world is changing every day but I don't see it completely going 180 degrees. It just doesn't sound logical.

King: I'll have to educate myself on the facts of that. I do recall some sort of rate modification, but I wasn't managing the rate review process at the time.

Salganik: Did that have to do with the moratorium on the tax…?

Charbonneau: I think it was a tax…

[cross talk]

Katseff: [The tax] was half of it, but the other thing we were told was the amount of claims came in much lower than expected.

King: I'll take a look at that.

Dr. Hittner: It is six o'clock, and I want to respect the time, does anybody else have something they would like to say?

I hope this has been beneficial. I know what the issues are. Al is there every time reminding us that the issues are the rates, the rates, the rates. So, we know that. We will look into the individual vs. small business market issue. Other people have brought up things, like group purchasing that used to be allowed through the chambers, and things of that nature. We haven't seen that in a long time. I don't know where that stands.

Ward-Smith: Has that been brought up again?

Dr. Hittner: It's been brought up, but I don't think much has happened with it.

Katseff: I thought that was a federal law also.

Coppolla: Commissioner, if you're going to be looking at – I'm actually chair of the SBA's summit on health – If you're going to be looking into that, that was actually a big issue the past couple years at the summit, individuals having access to the business market, or the corporations that don't have anybody on the plan, and have to be a corporate – who can I coordinate this with in your office, so that basically we can work together and find out what's going on to get this done, because I've been working with Rep. Ruggeiro on this also, just to get this put forward again?

Dr. Hittner: Cory will give you his card. He's the man. Mark would also be good as a contact.

Coppolla: One last comment – as a financial person, here's my thoughts: If our GDP pays 17.5% for health care and the rest of the world is paying half that, and you look at the compounding of dollars where [indecipherable] compounded over ten years will double, we're at a critical stage now, in a lot of ways. We can't just keep talking about this anymore. Matter of fact I read something this morning and it basically said the President of Aetna indicated that he would be open to a single payer health care system in the United States.

Salganik: I saw that.

Dr. Hittner: "Medicare for all."

Coppola: Medicare for all. And, if that's going to be the solution to the problem, so be it, because we're gonna break. It's a matter of time.

Dr. Hittner: [laughing] So I never thought I would say "Medicare for all," but as we get into the complications of what's there, it might be a good solution. [laughter] Alright, thank you all very much, I hope you got something out of this.