Health Insurance Advisory Council

February 28, 2012

4:30-6:00 PM – Public Utilities Commission, Warwick, RI

Minutes

Attendance:

Members:	Bill Martin (Co-Chair), Chris Koller (Co-Chair), Howard Dulude, Pat Mattingly, Hub Brennan, DO, Karen Fifer Ferry, Bill Schmiedeknicht, , Pat Mattingly, MD, Phil Papoojian, Al Kurose MD, Herb Gray, Al Kurose, MD, Ed Quinlan, Peter Quattromani, Jeff Swallow
Health Plans:	Brian O'Malley, Shawn Donahue, Lauren Conway, Craig O' Connor, Patrick Ross
OHIC Staff:	Herb Olson, Angela Sherwin, Adrienne Evans, Maria Casale
Not in Attendance:	Linda Lulli, Jack Spears, Gregg Allen

Announcements:

Herb Olson shared a staffing update, Marti Rosenberg spoke about the upcoming Health Insurance Small Employer Task Force, and Herb reported on legislation that the OHIC had had introduced. Mr. Olson promised to get copies of the legislation to the HIAC members.

Medical Expense Trend Target Discussion:

Introduction

Michael Bailit began the discussion by outlining and addressing the 5 Requests and Questions posed by the Council at their January 17th meeting:

1. What does the Producer Price Index (PPI) look like for health care, and how does it compare historically to the common PPI?
2. How do the Medical Care CPI and the All Item CPI less Medical Care compare historically to other CPIs?
3. Why is the medical component of the CPI only 7% if Health Care is 20% of the economy?
4. Is there a Rhode Island CPI?
5. How have Rhode Island health insurer medical expense trend rates compared to national medical expense trend rates?

Please see the copy of Mr. Bailit's PowerPoint for more details on his answers. He concluded that of all of the different indices, the one that is the most useful for the Council's discussion is the "All Urban Consumers/All Items less Medical Care" index. He also noted that there is no Rhode Island-specific CPI, and that Rhode Island's small group medical trend (as represented by BCBSRI and UHC of NE Small Group Requests and Approved rates) is higher than the national average, as measured by Price Waterhouse Cooper.

Methodology Considerations

Mr. Bailit then repeated the 7 considerations that the Council could consider as it makes its decision on the Medical Expense Trend Target, first shared during the January HIAC meeting:

1. What is our objective for the target?
2. What should be the nature of the target?
3. How should the target be set?
4. Is the target a goal or a requirement?
5. What are implications if an insurer proposes a rate that exceeds the target?
6. What state resources (e.g., data, staff) are needed to successfully implement the approach?
7. What help (if any) will insurers need to meet the targets?
8. What are the risks to each approach for setting the target (e.g., medical expense reported as admin expense), and what steps might be taken to mitigate them?

Then, Mr. Bailit reviewed the decisions that the Council had made on the first 2 Considerations:

1) From the HIAC's 1-17-12 meeting minutes: "The Council agreed that the target should both define (or at least outline) an affordable rate of increase (does not define affordable and does not necessarily accept all current costs) and force more serious actions by insurers and providers to change price and utilization patterns to achieve that target."

   The Council reaffirmed this decision

   On the nature of the target, Council members reaffirmed that the target be a projected medical expense trend that:
   a. is insurer-specific
   b. is business line-specific

2) The majority of the discussion centered on how OHIC would set the target. In order to help the Council make its decision, Mr. Bailit presented a Strawman Proposal for Council members to discuss. Here is the Strawman Proposal in its entirety:

1. Use an index.
   - Indices are rigorously and independently calculated and reported with regularity. State-based forecasting would be complex, resource-intensive and prone to error.

2. Use the All Urban Consumers All Items less Food and Energy CPI.
   - The CPI represents consumer prices and thus will make more intuitive sense for rate payers than the PPI.
   - This version of the CPI is far less volatile than other versions.
   - While this version includes medical prices, analysis shows that exclusion of medical prices from the CPI has no meaningful impact.

3. Allow for possible base and reserve adjustments to the medical expense trend target.
    - The Council has expressed concern that base premium rates be considered, relative to one another and to external benchmarks. Otherwise, high base costs could be "baked in" to future premiums.
    - Particularly high or low reserve levels should inform medical expense targets for individual insurers.
    - Flexibility for OHIC is important because the assessment of base rate levels and of reserves does not lend itself to a simple computation, but rather demands an expert, individual insurer assessment.
4. Phase in the target over three years. OHIC would add a diminishing number of percentage points to the index-generated rate until reaching the target rate in Year 3.
    - Reducing medical expense trend to the index level will take considerable insurer effort and provider effort. Insurers are unlikely to be able to renegotiate contracts and make product changes within 12-18 months. So, too, are providers unlikely to be able to make sufficient care delivery changes within that time period.

    This approach would provide immediate rate relief without creating dangerous disruption to the stability of insurers and providers.

Council members affirmed the first two parts of the Strawman. Then, they discussed Parts 3 and 4 at more length.

- One member agreed with the Strawman's language about allowing the Commissioner to have some flexibility in setting the target, to consider price and reserve levels, and what would happen with a large non-recurring expense (such as moving offices). Mr. Bailit noted that there are standards that OHIC could refer to in setting the rates, such as RBC levels (risk-based capital).

  Members talked about the need to allow for the Commissioner to make modifications, but that they needed more information about what modifications would be allowable, to ensure that the Trend Target would not be so flexible that it would be useless.

  Mr. Bailit will return to the council with more information on that question.

- Members discussed the affect that the Trend Target would have on the system, noting in many cases that there would be significant changes in what people are used to:
    - One member said that employers would need to be asked if they would accept limited and tiered network products.
    - Another noted that setting the Trend Target could lead to disruption in the system, and that the goal could be to seek minimal disruption.
    - Other members said that disruptions would indeed be necessary in order to bring rates down, but that the process should be managed to minimize harmful disruptions, and that is why there should definitely be a phase-in, with employer and broker education about the necessary changes in the mix of insurance products. There would also need to be a change in the siloed delivery system, with improved linkages.

  This part of the discussion ended with an agreement for a phased-in target.

Next Meeting

4:30 pm March 27 (date moved) at DLT in Cranston

Agenda: Medical Expense Trends Targets: Draft Model and Insurer Reactions:

The meeting then adjourned.