State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
June 25, 2013, 4:30 P.M. to 6:00 P.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Attendance

Members
Bill Martin (Co-Chair), Christopher Koller (Co-Chair), Steve Boyle, Karl Brother, Rob Cagnetta, Howard Dulude, Herb Gray, Al Kurose, Linda Lully, Pat Mattingly, Pete Quattromani, and Vivian Weisman

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State of Rhode Island Office of the Health Insurance Commissioner Staff
Herb Olson, Linda Johnson, Kim Paull, Maria Casale

Not in Attendance
Hub Brennan, Wendy Mackie, David Mathias, Phil Papoojian

1. Introduction and Welcome
Mr. Martin and Commissioner Koller called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance.

2. Review of Minutes
The minutes from the May 18, 2013 HIAC meeting were reviewed and approved with no changes.

3. Office Updates

Commissioner Koller reported that the major focus of the office over the past month was forms and rates – and that OHIC would be making their rate announcement on Friday. There will revisions in hospital conditions of approval, and they will issue Direct Pay rates at the same time.

There has been a tremendous amount of work dedicated to these new processes, and the Commissioner thanked OHIC staff: Linda Johnson, Herb Olsen, Patrick Tigue, and Adrienne Evans.

The Commissioner reminded the Council that this year, the office was approving actual rates, not just rate factors, and those rates were pegged for a 21-year-old, buying a fully loaded plan. Then, the rates are adjusted by age and family size, based on a formula provided by the federal government. Also built into the rates are the estimated medical inflation for last year and the cost of new benefits, as well as the Affordable Care Act fees and taxes, and the effect of morbidity with the new populations coming in.

The Commissioner noted that the underlying medical trend is between 7 and 8% before any adjustments for morbidity – and that we continue to have challenges on the trend side. The office is releasing as much

information as possible – with a press release that is 5 pages long. Now, the rates will be handed off to the Exchange, and the office will move back to longer term projects.

Commissioner Koller made the observation that it is really demanding on the insurers to ask them to predict rates 18 months ahead of time (in other words, to predict what will happen in December 2014 in April 2013, based on January 2013 data). That's actually 19 months of prediction. One refinement that might help here is more frequent rate reviews, which would be in the consumers interest as well.

4. New Business

There were two pieces of new business

- Affordable Standards Evaluation Review
- Small and Large Group Approved Rate Factors Monitoring Data (Quarter One of 2013) Review

A) Affordability Standards Evaluation – Presented by Michael Bailit, from Bailit Health Purchasing (by Skype), with Marge Houy in the room to assist.

Commissioner Koller stated that OHIC contracted with Michael through rate review dollars to do a review of Affordability Standards, which would be a more formal evaluation than the office could do (but less formal than peer reviewed piece). At this meeting, Michael presented his findings (from interviews and data analysis) and in the fall, will make recommendations. OHIC will look to Michael's advice for reforming standards.

Michael began his presentation with a review of the Affordability Standards:

1. Primary Care Spending: Expand the requirement to increase primary care spending by 1% per year; increase the percentage of funding directed to non-fee-for-service activities by 5% per year
2. Medical Home Support: Spread the adoption of the patient centered medical home
3. Support Currentcare : Financially support Currentcare, the Rhode Island health information exchange
4. Reform hospital payment arrangements via six hospital contracting conditions

For each standard, Michael addressed three considerations:

1. Insurer compliance
2. Value of the standard, i.e., does it represent an efficacious policy to achieve OHIC's desired aims?
3. Recommendations for modifications (if any)

Michael made these general points about the Standards:

1. The Standards have broad-based support and promote good public policy to lower costs and promote primary care services.
2. The State's activities created momentum for real change
3. Having the state as a partner was essential to making change happen "on the ground."
4. Standards appear to have been effective in:
    a. promoting Medical Home transformation, and
    b. slowing rate of hospital cost increases.
5. The Standards have been successful in changing payer/hospital contracting dynamics and in advancing outcome-oriented quality programs in hospitals.

Then, he went through each standard, describing his assessment of each one. See his full powerpoint report here: http://1.usa.gov/1aHzJLg

Other observations that Michael made were:

In total, the standards have broad-based support and are promoting the public policies you have endorsed. But not all stakeholders are enamored. There is overall concurrence that they're having impact.

Some particular areas of impact:
Promoting medical home transformation – a substantial impact.
The standards have had enough impact on hospital costs to slow rate increases.
They have changed the dynamics and introduced quality in a much more meaningful way.
Payers have made significant investments in primary care over time, and spending is much greater. (While Michael considered the possibility that the increase represented a drop in overall spending, they found that the percentage rose.)

Michael noted that the impact that Standard One had on primary care practices varied. Within Blue Cross & Blue Shield of Rhode Island, just 35% of practices were affected, but within UnitedHealthcare it was 59%. And, those who were touched, were touched significantly. Practices spent the dollars on developing infrastructures to operate primary care medical homes, including staffing, equipment, etc.

Emergency Department visits per thousand visits declined a little bit in 2011 – and ambulatory sensitive care visits decreased slightly. Michael noted it could have been to the recession – maco economic. With 2012 and 2013 data, we will know more.

On Standard 2, Michael shared that three commercial payers provided ongoing support to the Medical Homes, while Blue Cross and United both expanded their own medical home project. Michael stated that to expand the impact, there would need to be an expansion to more practices.

On Standard 3, Michael noted that it was difficult to tie the investments in CurrentCare to tangible benefits or affordability outcomes because of the nature of the HIE.

On Standard 4, Hospital Contracting Requirements, Michael went through the 6 elements of the requirement, noting that they had varied results.

There is also a challenge with these requirements and the standards when they don't get applied to self-insured companies.

Michael also noted that he found some wondering if the OHIC Hospital Requirements would be short-lived, and thus he questioned whether they changed as quickly as OHIC hoped they would. He added that the payers acted in good will to act on the requirements OHIC put forth.

In response to questions from Council members about what Michael's recommendations would be and what he thought OHIC should do about some of the challenges, Michael said that what is really needed is leadership:

A few large provider organizations, saying we need to proactively move into this direction.
Leadership from payers.
Pushing and prodding from state government a third factor.
Action and engagement from the employer/purchaser community.

B) Small and Large Group Rate Factors Monitoring Data

This report was based on a memo from Patrick Tigue – the results of the rate filings from carriers during the first quarter of 2013. OHIC used an audit mechanism to determine what was quoted as product renewals versus the approved/expected rate increase – and reported on each carrier.

Blue Cross: The major takeaway from the review was that Blue Cross did not come close to their first quarter target, which led them to ask for the mid-year review.

Commissioner Koller noted that in response to feedback from advisory council, OHIC made the percentages in the report smaller, so that we could see the distribution better.

Tufts: This carrier is smaller, so it is harder to see systematic rate increases, but the data show that they were significantly over their target for the year in the first quarter.

United: A topic of concern is their uneven distribution in the small group. What they are charging is considerably above what was granted for small group market and explains their request for a rate increase for 2014.

This is our second or third quarter of this sort of audit – but remember that carriers are accountable on a yearly basis. We have never had this level of scrutiny, and Commissioner Koller noted that it is interesting. He said that he'd like to use this for more discussion with the broker community.

Koller noted that there is a 20% increase cap is in statute – to fight rate shock. When a council member asked whether any increase above 20% is against the law, Koller responded that through this process, he expects to see these practices diminish and that carriers have work to do.

5. New Business

Public comments were then solicited by the council.

Public Comment;

Keith Dempty, from the RI Interlocal Trust stated that he thought that findings on the Affordability Standards were interesting – but that the proof is in the pudding, and the rate filings from carriers are seeking 7 to 10% increases. What's the disconnect? If these standards are taking effect, why are they not impacting the trends?

Council members discussed this. One response was: Look at Blue Cross or CSI or United. There is variability to how much the practices have transformed. Some are nascent, some are farther along – and the number of practices who have achieved a large transformation are small. That's why it hasn't happened yet.

Commissioner Koller said: Look at the big picture. We have a tegulatory strategy for delivery system change, but that doesn't replace leadership – which is very, very important. Where you see more transformation, you'll see more leadership. We also haven't engaged patients – and to reduce costs, we need to do that. The self-insured companies are more likely to do it – offering a financial incentive to change behavior. This is not something a regulator can do.

Also, Gus Mannochia from Blue Cross offered a correction of affordability numbers, saying that if you look at Blue Cross' fee schedule, it's three-tiered. There are different contributions of dollars to providers: those with a baseline participation, another with electronic health records, and a third for providers in the Primary Care Medical Home program.

Commissioner Koller made a final comment at this, his last meeting: In spite of Keith throwing in a cose of reality, I want to close by thanking the members of this council. It is difficult to get people to be engaged in the kind of conversation we've had for the last half hour on these types of issue. I am really happy for your willingness to engage and provide guidance to me and to the office.

6. Next Meeting

Mr. Martin closed by noting that the council's would not meet in the summer and would reconvene in September. He thanked everyone for their attendance and the meeting was then adjourned by Mr. Martin and Commissioner Koller. A short celebration recognizing Commissioner Koller's tenure was held after the meeting.