State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
July 16, 2019, 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

Co-Chair Commissioner Marie Ganim, Co-Chair Stephen Boyle, Shamus Durac, Karl Brother, David Feeney, David Katseff, Laurie-Marie Pisciotta, Hub Brennan, Daniel Moynihan, Al Charbonneau, Lisa Tomasso

Issuers

Heather Beauvais, Neighborhood Health Plan of Rhode Island
Lisa Holland, United Healthcare
Ryan Benton, Aetna
Deb Hurwitz, CTC
John Beretta, Tufts

State of Rhode Island Office of the Health Insurance Commissioner Staff

Cory King

Not in Attendance

Vivian Weisman, Deb O'Brien

Minutes

1. **Welcome, Introductions, and Review of May Meeting Minutes**

   Stephen Boyle called the meeting to order, welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance, and asked for a motion to accept the May minutes. The May minutes were approved as submitted.

2. **RIREACH Consumer Update**

   Shamus Durac gave a RIREACH consumer update. Over May and June RIPIN saved Rhode Islanders $115, 859. In addition to RIPIN's normal work they also had their annual breakfast in June. Shamus thanked everyone who was able to make the breakfast and for all of the ongoing support for RIPIN's

work. RIPIN is not currently seeing any major trends in the commercial market that they are worried about, most of the worrying trends are occurring outside of commercial insurance.

3. **2020 Rate Review Status Report and Discussion – Impact of Reinsurance Program**

Cory gave a presentation about OHIC's current rate review process. On May 17th and May 31st the office received the 2020 rate filings from the carriers covering the individual, small and large group markets. Each year once we take in the rate filings, we evaluate them for completeness, and credibility and we wait a couple weeks before we publish what was proposed. We released a press release about the rates, and there was an article in the ProJo as well. At the time the article was published the state's budget was not passed. As many of you know, there was a reinsurance program under that budget which would reduce individual market rates – so we requested two sets of rate filings from insurers, one assuming reinsurance passed, and one assuming that it didn't.

The reinsurance effect for each of these carriers is different because the health mix of the population among each of the carriers is different. On our website the specifics of all of the rate changes are listed, and if you want more information about any changes you can view our press release on the rates on our website as well. Rates are presently under review -we received the filings in May and expect to have preliminary conclusions ready by the end of the month.

David Katseff asked, how does the individual mandate impact rates, and secondly, the small group market is not impacted by reinsurance, correct?

Cory responded that as part of the budget there was a shared responsibility payment provision (individual mandate) which became law. The rates reflected in the press release incorporate the effect of the individual mandate.

David asked if we have any projection of how it will impact overall premiums?

Cory responded that it is likely the mandate should only improve the risk-pool.

Commissioner Ganim added that the section of the budget that pertained to the shared responsibility mandate and the reinsurance program were intended to stabilize the market and maintain the coverage that we have in the state – they weren't necessarily intended to bring new people into the market. We did not anticipate to gain people, it was meant to keep our current uninsured rate as low as it currently is.

Hub Brennan commented that with all the work to bring costs down in the primary care world, it is disappointing to see double digit rate rises even in the small business market – having said that, relative to drivers, you are confident that the drivers are the same – there is nothing new to deal with or address?

Cory responded that there is nothing new – except for the reinstatement of the federal provider tax.

Hub responded that, as a general observation, a manufacturer in Rhode Island who sees a 10% insurance increase each year, 100% increase over 10 years, would most likely go out of business.

Steve Boyle commented, this reinsurance program is important – rates are being reduced in the individual market and also in the sole proprietor market – and we are basically a state of sole proprietors. I think the impact of this program and what the committee did to bring it about will have a huge impact. We do need work on the small business market, but I think it is very important that we get the message out that this program is very beneficial.

Commissioner Ganim commented that we designed the reinsurance program in a way that mimics nine other states, that proposal went to the federal government on July 8th. The next step is a 30-day public comment period at the federal level.

David Katseff commented, looking at the requested rates that came in from the different insurers, if I remember, we talked about the cost-growth goal of 3.2% maximum increase of cost, and a whole bunch of different entities signed onto that- including the major insurers. Where is that 3.2% supposed to show up? We saw the requested rate increases, and a except for a couple, almost everything is multiples of 3.2% - so how do we see the cost growth goal that the insurers signed up for?

Commissioner Ganim responded, the cost growth target is a global target – so it is for all health care spending in the state. So it is difficult to take one segment and say it is all going to be on their backs. We are coming up with a benchmark now – so soon, we will have the data for what the 2018 spend is – and then that 3.2% is what we will use once we have the 2019 data. At that point we can compare the years and be able to call out what is the largest drivers.

David Katseff responded that he comes back from these meetings to a small group of people at his company – and one of the things he discussed a couple meetings ago is this cost growth target and that we can look forward to costs rising no more than 3.2%. I thought that was an across the board group of goals instead of global.

Cory responded that sometimes in the small group market risk pool for smaller carriers, a handful of members having very costly health care needs can really skew the costs for everyone. We don't expect each insurer, and each insurance group to grow at just 3.2%

4. Affordability Standards Revisions and Public Comments

Cory began by explaining the original idea and construction of the Affordability Standards. We have created a set of modifications for these standards that we are presenting today. We have entities 30 days to give comments on these changes. The comments and the document that Cory is presenting on are both on our website for anyone to access. During the months of June and July we have been

narrowing down the comments and combing through the policy ideas that we would like to pursue. Ultimately, we hope to have regulations amended, adopted and effective by January 1, 2020. The Affordability Standards have four main goals: improved health insurance affordability, improved health care quality, better integration of physical and behavioral health care, and reduced administrative burden and improved clinician wellbeing.

We received comments from 14 entities ranging from health insurers, hospitals, ACO, nonprofits, and others. For primary care investment & care transformation we proposed three possible options: one was to slightly increase the primary care spending target from 10.7% too 11%. We also proposed modifying the definition of primary care spend. Finally, a distinction between direct investment vs indirect investment exists, and we proposed eliminating that distinction. The comments we received were a mixture of support and concern.

Dan Moynihan asked if there were any comments looking to get rid of PCMH support?

Cory responded that health plans did comment that they do want to focus on initiatives that do generate a return on investment so that other initiatives are not crowded out. In general, people were supportive of continuing support for PCMHs.

Cory continued: Specialists has been a challenging subject to figure out exactly what our strategy should be. Providers and insurers are doing a lot of work around payment reform – it is largely focused on primary care and hospitals. It is challenging to incorporate quality measures and improve coordination between PCPs, hospitals, and specialists. Our proposal was to support improved cost-effective specialist services through implementation of reference pricing. This proposal was met with concern from commenters, and they recommended efforts to more actively engage specialists.

Hub Brennan commented, in regard to the specialists, the accountable entities are working very hard to help solve that problem themselves. Not only price, but access – we found that in many cases the access is not there. The market is hard at work to increase the quality, access and affordability of these services.

Al Charbonneau commented that if you think of the question of affordability – there are three things you can impact: hospital costs, drugs, and specialist costs. Those are the three big buckets. Al recommended not backing off from the specialists – insurers have said in the past that specialist prices in Rhode Island are far beyond the prices in other states.

Cory assured Al that we will not be backing down on this issue and that we will be focusing payment reform for the specialists through the health plans. There are various methods we are considering implementing.

Administrative burden was another pressing area for us – one of the difficulties was pinpointing what the major stressors are. We proposed actions to reduce burden and burnout, and some

commenters questioned whether regulation was the most appropriate mechanism to address this issue. Providers in general were supportive of these measures.
Steve Boyle asked if any commenters gave a suggestion of what could be a solution to burden/burnout?

Cory responded that for the most part no – some commenters encouraged us to work with various groups to look into this issue.

Hub Brennan commented that the prior authorization process can be a large burden, and the conversation around it is often confrontational and frustrating. The prior authorizations are often a real time-cost to the practices. The cost of physicians doing data-entry is costly. Particularly for small practices the burden of data-entry is huge.

In general, there was support for the continuance of payment reform. We received a plethora of comments on payment reform – some commented that payment reform should have an equal emphasis on quality.

Hub Brennan commented that it is time to the payers to consider fee schedules – it may help lessen the burden on primary care doctors.

Cory continued, OHIC believes that APMs for primary care can be a tool for achieving some of these affordability initiatives, to date it has not lent itself to a voluntary approach, so we think a regulatory approach is necessary. Regulated Primary Care APMs received mixed comments, some commenters opposed in general, some opposed a mandate, some were in favor, and some proposed broadening the definition of primary care APMs.

Hub Brennan asked, in concept, is the thought to cap the entire universe of revenue or is it just the revenue that is still within fee-for-service?

Cory responded that that is the starting point. In general, you identify the claims you would pay primary care for primary care services and create a prospectively paid payment.

Karl asked if the Medicare payment model that Milbank suggested makes sense for this?

Cory responded that what they generally do is place a portion of the primary care practices revenue at risk and in some cases, they give practices substantial infrastructure payments and then they also withhold a portion of fee-for-service payments and pay that out prospectively, which is like a partial cap.

Hospital Rate Cap: We have heard from the Hospital Association and other hospitals that since they are on the lower end of the payment distribution, that the rate cap has locked in this variation – they consider the payment variation to be unwarranted between them and other hospitals. They

also pointed out that there have been changes to Medicare payment policies and Medicaid rates that have undermined their revenue potential and they face some challenges. As part of this proposal we said we could maintain the hospital rate cap as is, uniform standard across all hospital contracts, or, we could try to address the disparity in pricing variation by allowing a higher rate cap for lower-priced hospitals and make it contingent on hospital performance – and, nobody liked that option. HARI commented that in general the retention of the rate cap has burdened hospitals, they are running negative margins, hospitals in RI are finding it hard to compete for talent due to the reimbursement rates.

Lisa Tomasso commented that the numbers on the map indicate what is referred to as the area range index – it is an index that is assigned to payment reimbursement for Medicaid fee-for-service through CMS. This was put together to demonstrate to members in the US Senate Finance Committee how individuals in the workforce can easily travel to surrounding states where doctors are getting paid significantly higher than in Rhode Island.

The Hospital Association of Rhode Island, CharterCARE, South County Health, and Lifespan all commented on the hospital rate cap changes. Generally, insurers supported the rate cap as is.

Cory commented that the rate cap has a strong evidence-basis behind it as reducing medical expense trends.

Al Charbonneau commented that the rate cap, according to the Harvard-Standard study, is the only factor that is containing premiums in the state.

Cory encouraged everyone to read the comments and to reach out to us if they have any comments, suggestions or ideas.

David Katseff asked how many organizations are using alternative payment methods?

Cory responded that about 50% of commercial medical payment are tied to an alternative payment model – the provider community is very much on board with this.

Al Charbonneau commented that it is also important to note that over 98% of those payments are fee-for-service.

Next Meeting:

- Tuesday, September 24, 2019 from 4:30 – 6:00 PM at the Buttonwoods Municipal Annex and Community Center – 3027 West Shore Road, Warwick, RI 02886