State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
January 6, 2020, 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, Al Charbonneau, Teresa Paiva Weed, Vivian Weisman, Daniel Moynihan

Issuers

Shawn Donahue, Blue Cross Blue Shield of RI
Heather Beauvais, Neighborhood Health Plan
Stephanie Deabreu, UnitedHealthcare

State of Rhode Island Office of the Health Insurance Commissioner Staff

Cory King

Not in Attendance

Hub Brennan, Deb O'Brien

Minutes

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

   Stephen Boyle called the meeting to order. After introductions, Stephen asked for a motion to accept the November meeting minutes. The minutes were approved as submitted.

2. **RIREACH Consumer Update**

   Shamus Durac gave a year-end update on RIPIN and the RIREACH call center. Last year RIPIN saved consumers a little over half a million dollars. When looking into consumer metrics over the past year, over 93% of people said they would recommend RIPIN to someone else. Open Enrollment is just finishing up and it went more smoothly than any other has before. There was an increase in the normal rate of calls, but not as high of an increase as they have seen in previous Open Enrollments. RIPIN sees that as a huge indicator of progress, and it shows how well HealthSource RI handled communications, particularly about the mandate. Last month they collaborated with OHIC on a case which had a fully-insured commercial consumer who had been on a particular drug for a condition for about seven years and her plan decided she need to try another generic version of the drug and she was worried she would have to stop working in the community if she had to change drugs. They were able to ensure the consumer was able to continue to use the original drug they needed.

Stephen Boyle asked if there has been any type of consistent theme in the calls RIREACH is receiving? Shamus responded that there was not a particular issue, in the past month the phone calls have revolved around general open-enrollment issues and questions. Shamus commented that there was an issue for part of open-enrollment, there was a short period where HealthSource RI's phone system was effectively down.

Stephen commented that he has heard various complaints from small businesses complaining about the individual insurance mandate. Shamus replied that RIREACH has not yet received any calls with issues regarding the mandate.

David Katseff commented that he has been communicating with Lindsay Lang of HealthSource RI the last few days because he knows people that still have questions about the mandate. He commented that the fact that RIREACH is not getting a lot of calls about the mandate might be good news, but it may also be bad news, indicating that people may just not be paying attention and may not know about the mandate. David asked Lindsay if there are going to be any more open enrollment periods during the year for those people who have just now become knowledgeable about the mandate? Lindsay communicated to David that there is an approximately two-week window past the December 31st end date of Open Enrollment for consumers to sign up for coverage due to the communications error HealthSource experienced during Open Enrollment. Besides that, there are no plans at this time to hold another Open Enrollment until the next period at the end of the year.

Stephen Boyle commented that one of the things that did come up, and that was brought up with some other states is that after you do your taxes, you will still be given the penalty, but afterward you will have an Open Enrollment period opportunity. Teresa asked, if this would be in April/May where this would happen? Stephen confirmed that.

Stephen commented that something the articles that were in the paper about the mandates that they left off is the actual impact we had by funding reinsurance had a corresponding reduction in rates.

Teresa commented that she did hear people complain about the mandate but also, she wants to complement the 5 questions interview Commissioner Ganim did with PBN. Teresa said that that article is a great summary for people to see the whole picture about the mandate, why we have it, and its impact.

3. **Pharmacy Formularies Regulations Overview and Discussion**

Commissioner Ganim gave an overview about OHIC's role in pharmacy formularies regulations. OHIC inherited two different laws a couple of years ago from the department of health that relate to issues around formularies. The first law has to do with network plans – it is the law that says when an insurer, carrier, or HMO, has a network of providers there are certain expectations for both quality and availability of services. In the network plan regulations, OHIC has said that there are

situations when there are formulary changes and those include these three: Medication covered on the formulary, medication tiering, and cost sharing.

In the network plan law, prior to making any formulary changes for a network plan, a health care entity must provide at least 30 calendar days direct notice. So, if an insurer is going to be making any changes to the formulary, they need to give at least a 30-day notice to both the prescriber and the consumer, if they are going to be adversely impacted.

The other law governs what happens if someone is caught in a formulary change they do not agree with, in a situation where there is step therapy or some other prior authorization requirement. This law is the benefit determination utilization review act, which is widely used when there is a situation where a beneficiary or a provider want to appeal a decision being made by an insurance company. OHIC has set up a very similar process for a formulary change as we have in place for when you are denied access or coverage for a certain benefit. The first step is an internal appeals process, which means the appeal goes to the insurance company and the they review that internally. That appeal needs to be reviewed within 72 hours, or no later than 24 hours if it is urgent. The determination of whether or not the beneficiary could be adversely impacted making it an urgent request is determined by the provider. If the internal request is denied than you can go through the external appeals process. That appeal goes to an independent review organization that works with the insurance companies and the providers to independently examine cases and decide whether or not the appeal should be sustained or overruled. The timeframe for the external review process is also 72 hours, unless it is urgent then it is 24 hours.

Key language that was added to OHIC regulations relative to the appeals process: Each agency must perform its benefit determination and appeals process in a manner to ensure quality, access and continuity of care. Including transition of care, and the welfare and safety of the patient.

Dave Feeney commented, if there is a 72-hour appeal, what happens in those three days that the patient doesn't have anymore medication? Also, I know in the statute the insurance company must notify the provider and the patient – I would say that 90% of the time the patient doesn't read what they are getting from the insurance company, and they may not understand it. Something that I don't see in the regulation is if the patient can be provided with an emergency supply for those 72 hours.

Commissioner Ganim responded that in a situation where there could be a break in the continuity of care – that kicks the process into the 24-hour determination period. Dave replied that there are many roadblocks that can often get in the way of the consumer receiving the medication they need, even with a 24-hour required period. He continued, commenting that he knows insurance companies are working hard and knows all of the constraints they need to go through, but there should probably be more done to ensure continuation of care for the consumer, to ensure in that time they don't suffer a medical emergency. Commissioner Ganim suggested that some of the OHIC regulators will reach out to David to discuss the details further.

Shamus Durac asked, are pharmacies notified when the insurance company sends out formulary changes to consumers/and if they are able to respond to these changes? Dave responded that it depends on what the insurance company systems will allow. Shamus replied that if the pharmacist was made aware, that could be a point of contact for them to inform the consumer about the change, since often consumers do not read, or may have trouble understanding notices from the insurance company. Dave continued, stating that another issue is the supply issue of medications – there are a lot of manufacturers that are getting out of the manufacturing of certain drug products because the profitability is not there, this happened to Rhode Island in November with opioids.

Laurie-Marie Pisciotta asked what the harm would be to extend the 30 days to something more like 60-90 days? Because for mental health patients there is a lot of trial and error to find the right medication/combination of medications. And when they are asked to withdraw, there are excruciating withdrawal symptoms for these patients. Commissioner Ganim responded that the 30 days is in law, in order to change the time frame, it would need to be brought to the General Assembly.

Vivian Weisman commented that considering all of the roadblocks, keeping a patient-centric philosophy on this topic is essential. There is the money-side and there is the health-side.

David Katseff commented that the first law mentioned is only involving changes in a formulary, but the second law covers any new request for a drug not covered on the formulary. Commissioner Ganim confirmed that was correct.

4. **Market Stability Update – Small Business Insurance Group**

Commissioner Ganim gave an update on the Small Business Insurance Group, the progress the group has made so far, and their goals. This group was put together by OHIC and HealthSource RI (HSRI) in collaboration with the Rhode Island Public Expenditure Council (RIPEC). RIPEC had noticed that many small businesses were struggling to find affordable, quality health insurance for their members. The idea for this group was to build upon the successes OHIC & HSRI had with improving the Individual Market to improve the Small Group Market.

The meetings began by discussing and addressing the problems in THE Small group Market and establishing some goals for what the group hopes to accomplish. The group has since begun to collaborate with national experts and they are in the early stages of considering various policy options that could give relief to small businesses.

Some of the findings the group have discovered so far is that even though OHIC is seeing a significant decline in the amount of small businesses that offer insurance, Blue Cross, who is the major carrier in that market, is not seeing a disruption. So even though we are seeing a decrease in the number of people in the market, it is not necessarily the healthy people that are leaving. What we found was that fewer businesses are offering insurance. There are most likely many reasons for that, and that is why we are sending out a survey to find out the challenges businesses face to offer health insurance.

We know that the problem is not an unstable market, the problem is not healthy lives leaving, the problem is probably related to the cost of the products. One of the policy options we are looking at very closely is: are there ways to design products that will be less expensive? However, businesses are not necessarily picking those, as data shows many businesses choose the more expensive plans. We are also going to look closely at SHOP, the HSRI exchange, to see if there is a way to incentivize the purchase of lower cost plans through that mechanism. Another option we are considering is a reinsurance program for the Small Group Market – in this case there is no federal money so we would need to find a funding source. Additionally, we have discussed some regulatory protections aimed at strengthening the Small Group Market – one of those being oversight of stop loss plans.

Karen Malcom asked how many lives are covered in the Small Group Market? Commissioner Ganim responded that it is about 52,000 but ten years ago it was closer to 90,000. Karen asked: is there an understanding how many of those lives may be able to be covered in the state's RI Share program? Commissioner Ganim responded that that is a great question, but we don't know that currently.

Commissioner Ganim commented that even though we have seen this decline in the Small Group Market, 96% of the state's population does have insurance, so clearly, they are somewhere. Another subject the group is looking at is health reimbursement accounts (HRAs).

Steve Boyle commented: One caveat to that is if you take the HRA option, you do not get the federal ACA subsidies.

David Katseff asked, if the employee goes to the individual exchange and gets an insurance package, how would they differentiate them from anyone else who walks into HSRI and asks for an individual policy? HSRI is in the process of establishing how they will implement, but they will definitely need the employee to identify that they are funded by their employer.

Karl Brother asked about brokers in the Small Group Market – are the brokers paid by the insurer? Cory King responded that broker payments are part of the rates in the Small Group Market. Steve Boyle commented that brokers are not paid/do not work with the Individual Market or with HRAs. Karl asked if the HSRI navigators are available to small businesses as well? Commissioner Ganim responded that we are not positive if navigators focus on SHOP. Karl responded that it is an opportunity, for the small businesses: to avoid a broker fee, perhaps there is a design opportunity for savings costs if they instead turn to the support from HSRI.

David Katseff asked if there are any theories as to why the small business owners are choosing higher cost "better" benefit plans than the Individual Market? Commissioner Ganim responded that it is the business owners who are choosing the higher benefit plans.

Teresa Paiva Weed commented that she has always seen health insurance to be a way to attract the best employees and to keep employees, and what you see in a lot of these lower paying industries is

that these employees may want more money, rather than insurance? Employees now have an option to buy insurance outside of work, so there may be less of an incentive.

Shamus Durac commented that we are not seeing established employers that have been offering coverage stop offering coverage. What we are seeing is that employers who were offering insurance are leaving the market and new small businesses are coming into the market, and perhaps younger employers/employees are not offering coverage.

Karen Malcom commented about the average or median wage for employees. For lower wage workers, the cost has just gotten too high for them. That speaks to the state needing to do a better job of promoting the Rite Share program. The most important factor in enrollment is affordability.

5. **Affordability Standards Revisions Overview and Discussion**

Cory King gave an overview about the revisions being made to the Affordability Standards. OHIC entered 2019 with the intention of revising our Affordability Standards, it is something we do about every five years. Today's presentation is to give a run-down of the Affordability Standards as we have proposed them – this is the third generation of these regulations.

Average premium rates, in all three markets that OHIC regulates, have increased significantly over the past several years compared to the average rate of economic growth. Without these standards and other preexisting policies, and the great work of providers and the health plans, these premiums would have risen even higher. The Affordability Standards are aimed at both increasing the affordability of these products, but also promote consumer protection, access to care, and health care quality.

In the past we focused largely on transforming primary care and then expanded that out to broader organizations of care like accountable care organizations. The timeline of the Affordability Standards revisions is as follows:

- December 6, 2019: Notice of Proposed Rulemaking
- January 10, 2020: Public Hearing on Proposed Rulemaking
- January 16, 2020: Public Comment Due
- Post January: Review public comment, make necessary revisions to the proposal and promulgate final regulations.

We began this process with an advanced notice of proposed rule-making in May, which set forth some ideas. We took the comments we heard to revise the proposed regulation and then do a cost-benefit analysis on the prosed regulations.

Overall, the goal of the revised standards is to:

- Ensure sustainable funding for advanced primary care.
- Support the integration of behavioral health into primary care by removing administrative encumbrances to integration.

- Transition payment models to greater downside risk and prospective payment to strengthen incentives for cost reduction and allow greater clinical flexibility and support for team-based care.

In general, what OHIC is proposing in terms of payment reform is taking some pre-existing policies around risk-based contracting ad codifying them into regulation. The idea is to increase the amount of financial risk the providers are bearing for the total cost of care to incentivize behavioral changes, which ultimately, we hope will improve cost performance – and thereby decrease premium growth, in a hope to bring it closer to the rate of economic growth.

Primary Care practices are one of the foundational units of the health care delivery system. We want to have policies that impact the basic units of the delivery system.

The first overarching proposal here is to create a minimum baseline of payments that are locked into alternative payment models so that we can ensure that those incentives for cost reduction and quality improvement remain.

Karl Brother asked if it is a minimum? Cory agreed and said that this language should read “at least” 50%.

In terms of risk-based contracting, the regulation is proposing that there be standards for certain risk-based contracts, for certain types of providers, increasing over time.

Primary care payment reform:

- The proposed amendments require commercial health insurers to develop and implement a prospectively paid APM for primary care.
- For Qualifying Integrated Behavioral Health Primary Care Practices, health insurers shall develop and implement a prospectively paid APM for primary care that compensates practices for the primary care and behavioral health services delivered by the site.
- Commercial insurers shall meet annual targets for RI resident covered lives attributed to a primary care APM beginning with 20% by January 1, 2021 and increasing to 60% by January 1, 2023.

We have had a set of hospital contracting regulations in place for over a decade, the prominent feature if the annual inflation cap on hospital fee schedules which applies to inpatient and outpatient services that are performed by hospitals. Prior to the implementation of that policy there was very substantial variation in case mixed adjustment payments to hospitals. Hospitals have told us over time that they are being disadvantaged by this rate structure which may or may not reflect the historical bargaining position of different hospitals – hospitals have a certain level of care they want to deliver, and they want some relief. In general, OHIC has a number of competing objects and interests we have to balance – affordability is the primary one, but also quality of health care workforce needs are another.

For each health plan, for their network of hospital providers, they would calculate a payment for discharge for each hospital that creates a distribution – that distribution will have a median – hospitals that are below that median would then be eligible for a rate increase enough to bring them up to that median.

David Katseff asked: is there the other side of the coin in this report? If you are allowing hospitals who are being paid less than the median to go percentages higher, are you also suggesting to hospitals above the median to get down to the median? Because if not, wouldn't this increase costs? Cory responded that we did consider whether we should make this a cost-neutral type of program. We ultimately decided not to do that. Hospitals have responded that they are suffering in terms of their balance sheets, they are facing competition from other states, etc.

Teresa Paiva Weed thanked Cory for the presentation and all of the hard -work that went with this. The HARI board definitely supports this, and one of the key factors is that it is not budget neutral. The one question is: is there an assumption in your analysis from 2012 to today that the quality incentives have been built into the base? Cory responded that in general they have.

Al Charbonneau commented that when we talk about affordability and concerns with our small and large group costs, and rise in premiums, hospitals are upward to 50% of the cost of premiums. And I think the only thing that has had an impact on premiums is the fact that we regulated hospital cost. So, the idea that we are going to put more money into hospitals just says to me that really, we should just stop kidding ourselves that we want to make health insurance affordable. You really should be keeping the regulations tight and forcing the industry to do something different. Frankly, I think this is a mistake.

Steve Boyle commented: echoing Al's comments, are we going to see an increase on the admin side because of this? Cory responded that that is an excellent question – there is a boundary at which the regulation of insurance companies stops, and I think some of that will take us into the domain of regulating hospitals, which is not within OHIC's domain. There is only so much you can require an insurer to do through contracting and oversight.

Al commented that the solution is not in regulation, the solution is in payment reform. It really requires a dramatic change so that the hospitals can look at it and say, we are going to be better off if we do this as opposed to that.

6. Public Comment

There was no public comment.

Next Meeting:

- Tuesday, February 18, 2020 from 4:30 – 6:00 PM at the Central Falls Neighborhood Health Station, 1000 Broad Street, Central Falls, RI 02863.