State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
October 20, 2020, 4:30 P.M. to 5:30 P.M.
Virtual Zoom Meeting

Attendance

Members

Co-Chair Commissioner Marie Ganim, Co-Chair Stephen Boyle, Shamus Durac, David Feeney, David Katseff, Laurie-Marie Pisciotta, Al Charbonneau, Daniel Moynihan, Hub Brennan, Lawrence Wilson, Sandra Victorino

State of Rhode Island Office of the Health Insurance Commissioner Staff

Cory King
John Garrett
Maria Casale
Emily Maranjian
Marea Tumber

Not in Attendance

Teresa Paiva Weed (represented by HARI staff)
Vivian Weisman

Minutes

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

   Commissioner Ganim called the meeting to order. After introductions, Steve Boyle asked for a motion to accept the September meeting minutes. The minutes were approved as submitted.

2. **RIREACH Consumer Update**

   Shamus gave an update on RIREACH for the month of September. The biggest trend recently has been individuals being charged for COVID-19 testing, predominantly for those being tested for work, especially in nursing homes. At this point most of those have been resolved, but some are still coming in. Additionally, there have been a few people in the last month who have been charged with COVID-19 treatment. In those cases, it was just an error in claim codes because their insurers did agree to cover the costs at no cost to the consumers. It should be noted that even at the peak only about a third of the call centers cases have been specifically COVID-19 related – they are still doing a lot of work helping Rhode Islanders who have trouble accessing benefits and are struggling with claims being denied. There are many cases of people trying to find access to insurance, especially due to losing employer-based coverage.

   Larry Wilson asked if RIPIN has a sense of what the demographics are for the people calling RIPIN? Shamus replied that that is something they want to work towards getting a better sense of. Currently they do not have that data, but they are in the process of retaining staff so that they are better able to estimate the demographics they serve. RIPIN does track both language and the zip codes they serve.

Steve Boyle asked if there is a specific market-segment where Rhode Islanders are losing their jobs? Recent articles have discussed a large decrease in tourism jobs in our state. Shamus replied that they do not have data for specific markets, but anecdotally they have had clients from various sectors, especially retail establishments early in the pandemic.

Karen Malcom commented that the question about the population RIPIN is serving is very important, and she thinks there is an opportunity for RIPIN to partner with the Parity Initiative and the Mental Health Association for a broad-based outreach effort to get the word out about RIPIN's services. This is very important for broadening the demographics for Rhode Islanders that are accessing the call center for help.

3. Market Conduct Exams: Update and Discussion

John Garrett gave an update on OHIC's Market Conduct Examinations. On March 20 of this year, OHIC completed the Behavioral Health Market Conduct Exams. The examinations were conducted across the four major health insurance carriers to measure compliance with the laws and regulations relating to coverage for mental health and substance use services. Across carriers, the major findings led the examiners to believe that in many cases care was unreasonably denied, delayed, or negatively impacted. Some of the specific findings included denials based on insufficient information, coercive conduct when communicating with providers, frequent short-term concurrent reviews, and issues with parity.

As part of the reports, carriers are required to submit corrective action plans which include revised policies and procedures. The corrective action plans are in-process, and compliance will be monitored by both the carriers and by OHIC. Each carrier will also conduct a separate parity analysis comparing behavioral health services to medical/surgical services. Part of the consent agreements stemming from the examinations involved contributions to the OHIC-created Behavioral Health Fund at the Rhode Island Foundation in lieu of penalties. Blue Cross Blue Shield of Rhode Island agreed to contribute $5 million; Neighborhood Health Plan of Rhode Island agreed to contribute $330,000; Tufts Health agreed to $150,000; and United HealthCare agreed to $2.85 million, in addition to a $350,000 state penalty. OHIC also has a new Market Conduct Examination ongoing now that involves the review of each insurer's provider network and its adequacy to ensure access to needed care.

Al Charbonneau asked if we know how many cases were reviewed? John replied that each report identified the number of cases reviewed in the BH Market Exams, they were in the thousands.

Laurie-Marie Pisciotta commented that she is grateful for these Market Conduct Exams – they are incredibly important for consumers. Laurie asked if the correction plans are available to the public for review, and asked to hear more detail about the parity analysis each insurer will conduct, and if that will be available to the public as well? John replied that the correction plans are not available to the public currently but in time at least pieces of these plans will be made public. In terms of the parity analysis, we want to see the analysis completed in the next month or so, with the audits being completed by the end of next year.

4. **COVID-19 Behavioral Health Fund at the RI Foundation: Overview and Update**

Zach Neider, Strategic Initiative Officer for Health at the Rhode Island Foundation gave an overview of OHIC's COVID-19 Behavioral Health Fund. The Market Conduct Examinations led to contributions from health insurers to create behavioral health funds at the Rhode Island Foundation. Blue Cross Blue Shield made an initial contribution in 2018, with additional contributions in subsequent years. Tufts Health Plan, United Healthcare and Neighborhood Health Plan made contributions in 2020. Using these funds, the RI Foundation managed two funds in support of the behavioral health needs of Rhode Islanders.

There are two funds created as a result of the exams: The Behavioral Health Fund, and the COVID-19 Behavioral Health Fund. The first was established in 2018 from the funding provided by Blue Cross Blue Shield of Rhode Island and was designed to support strategies and service models that enhance primary and secondary prevention and access to high quality, affordable behavioral health care services. In 2020, with the contributions from the remaining insurers, the COVID-19 fund was created with the intention to support, expand, and enhance the capacity of nonprofit organizations to deliver behavioral health services in response to the pandemic.

The first fund was composed of six grant recipient organizations with multi-year grants totaling $2.6 million. The focus on this first fund was longer term initiatives, many with focus on system change. In comparison, responding to the urgent need of COVID-19, the second fund had 65 total grant recipients with grants totaling $5.4 million awarded to support behavioral health needs related to COVID-19. The fund prioritized underserved communities and evidence-based practices and focused on general support for community-based behavioral health providers, including expanding telehealth capacity.

5. **Rhode Island Cost Trends Update and Discussion**

Megan Burns from Bailit Health gave an update on the Rhode Island Cost Trends Project. The Cost Trends Steering Committee, a group of providers, employers, consumer representatives and insurers, convened by the Governor, committed to a cost growth target in December 2018. A cost growth target is a benchmark for the annual rate of growth of total health care spending in the state. The target aligns with projected state economic growth. In February of 2019 Governor Raimondo issued an Executive Order affirming the target which was set at 3.2%.

This does not mean that an insured business' health care costs will grow only 3.2%. The cost growth target is a non-binding ceiling for overall growth in RI of health care spending across all purchasers, including Medicare and Medicaid. In order to calculate the per capita cost trend for the year preceding the cost growth target, OHIC requested that the state's four largest insurers submit total medical expense data in October 2019 for calendar years 2017 and 2018. Additionally, data was gathered from Medicare, and from Medicaid for non-MCO expenditures.

(To view all the data and graphs from the presentation, click here)

In terms of annual growth in commercial total medical expense by service category from 2017-2018, hospital outpatient and specialty care were among the highest with a 5% increase for hospital outpatient, and 7% increase for specialty care.

6. **Telemedicine Demographics and Disparities: Overview and Discussion**

Marea Tumber gave an overview of national telemedicine demographic data. The Telemedicine Advisory Group in Rhode Island's goal is to review existing telemedicine legislation, temporary emergency policies and language in the proposed budget article. Specifically, the group has discussed coverage and access, payment and program integrity, security, privacy, and confidentiality, and performance measurement.

While telemedicine can often increase access to care, we want to ensure that it does not exacerbate existing disparities in care. Populations lacking technology access tend to be from the same underserved populations with worse health outcomes and the ones who would benefit most from ongoing telemedicine enabled care. 26.3% of Medicare beneficiaries lacked digital access at home, making it unlikely that they could have telemedicine video visits.

The digital divide can be categorized in three different buckets: Absence of Technology, Digital Literacy, and Reliable Internet Coverage. More than one third of Americans do not have a desktop or laptop. 52 million Americans do not know how to use a computer effectively. In RI, 98.5% have access to broadband and 88.5% have access to a low-priced internet plan.

The proportion of visits attributed to non-Hispanic white and other patients increased after telemedicine scale up but decreased for African Americans, Latinx, and Asians. Pre and post COVID-19 we can say that there was an access issue for people of color.

With increased income comes an increase in access to telehealth visits. 70% of respondents with incomes over $100,000 had access to a telehealth visit while 36% of respondents that make less than $25,000 a year had access.

The Advisory Group has identified several opportunities for ensuring health equity and reducing disparities in access to telemedicine services including adding telemedicine access to inform network adequacy standards and providing statewide access to broadband internet.

David Katseff asked if there is any reason why the data shows that only non-hispanic whites have utilized telemedicine more after the start of the pandemic? Marea responded that there are multiple possibilities – it could be because they have better access to telemedicine, or that they have better access to care in general.

Larry Warner commented that there are no surprises in the data, but he is pleased that Rhode Island is number four in the nation in access to broadband internet. The longer that COVID-19 spreads, the greater the concern for people who do not have access to telemedicine services.

Al Charbonneau asked if anyone has done a survey on available facilities in rural areas where someone can borrow, or access a device for telemedicine? Marea responded that she does not know if that kind of program exists on a large scale.

Steve Boyle commented that there are stations at rest stops so that truckers can call in for a telemedicine visit, and he can envision something like that being done on a larger scale. Some businesses also have sign-in areas where people can take a telehealth call.

Sandra Victorino commented that she liked the idea of using people who are already connecting with the patients and clients – there tends to be a lack of trust when it comes to technology and if there is someone that can guide them it could help a lot.

David Katseff asked if we have seen if more people are getting health care through telemedicine who had not been going to see their primary physician before – or if people are using telemedicine as opposed to going to the emergency room? Marea responded that we do not have individual data for that – it is hard to say if it has replaced emergency department use, but anecdotally we have heard that.

Al Charbonneau commented that some pre-covid studies suggest that only 12% of claims were thought to be substitution of emergency department uses etc. Marea responded that Rhode Island utilization data from February – August of 2019 compared to February – August of 2020 showed a decline of 1% in overall utilization.

7. Public Comment

David Katseff requested a discussion on the potential merger between Lifespan and Care New England at the next HIAC meeting. Specifically, he is interested in what role OHIC has in the process. Commissioner Ganim responded that we would put it on the agenda.

Karen Malcom asked about the market conduct exams: will the corrective action plans ever be available to the public? And how should consumers expect their care to change with these correction plans? Commissioner Ganim responded that once we have approved correction action plans, we can summarize the findings. Additionally, we can work with you to communicate the results to consumers, either directly or through RIPIN.

Maria Lenz commented on the potential Lifespan/CNE merger: so far there hasn't been anything filed publicly with the Attorney General's Office or Department of Health. If that changes, she would be happy to provide any updates.

8. Adjournment-- The meeting was adjourned at 5:45 pm.