
VIRTUAL ZOOM MEETING
HEALTH INSURANCE ADVISORY COUNCIL
October 20, 2020
4:30 - 5:30pm

Agenda

- Introductions and Review of September Meeting Minutes **(4:30 – 4:35pm)**
- Rhode Island Parent Information Network (RIPIN) RIREACH Update **(4:35 – 4:40pm)**
- Market Conduct Exams (Update and Discussion **(4:40 – 4:45pm)**
- COVID-19 Behavioral Health Fund at the RI Foundation: Overview and Update **(4:45 – 4:55pm)**
- Rhode Island Cost Trends Update and Discussion **(4:55 – 5:10pm)**
- Telemedicine Demographics and Disparities **(5:10 – 5:20pm)**
- Public Comment

RIREACH CONSUMER UPDATE

MAJOR MARKET CONDUCT EXAM FINDINGS

- Application of clinically inappropriate UR criteria;
- Continuity of care and/or the health and safety of the patient;
- Frequent short-term concurrent reviews;
- Not giving sufficient weight to clinical recommendations of the attending provider;
- Denials based on insufficient information;
- Coercive conduct when communicating with providers; and
- Parity issues

MARKET CONDUCT EXAMS: CORRECTIVE ACTION PLANS

- Revised policies and procedures and other documentation addressing efforts to comply with each recommendation.
- Ongoing monitoring of Corrective Action Plans by the Carrier and OHIC.
- Each carrier will conduct a separate parity analysis

❖ In lieu of penalties the carriers agreed to contributions to a Behavioral Health Fund established by OHIC

  - BCBSRI - $5 million over 5 years
  - NHPRI - $330,000 over 3 years
  - Tufts - $150,000
  - United - $2.85 million plus $350,000 penalty

RHODE ISLAND FOUNDATION

Update on Behavioral Health Funds

Health Insurance Advisory Council

Zachary Nieder
Strategic Initiative Officer
October 20, 2020

Background on the Behavioral Health Funds

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- OHIC's market conduct examination focused on behavioral health parity policies led to contributions from health insurers to create behavioral health funds at the Rhode Island Foundation
  - Blue Cross Blue Shield of Rhode Island 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 contributions, RIF managed two funds (and issued two RFPs) in support of behavioral health needs in Rhode Island

Priorities for the Behavioral Health Funds

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Behavioral Health Fund

- In 2018, with funding from Blue Cross Blue Shield of Rhode Island, an RFP was issued to support strategies and service models that enhance primary and secondary prevention and access to high quality, affordable behavioral health care services

COVID-19 Behavioral Health Fund

- In 2020, remaining contributions from all insurers were pooled to create a COVID-19 Behavioral Health Fund and an RFP was issued with the intention to support, expand, and enhance the capacity of nonprofit organizations to deliver behavioral health services in response to the COVID-19 pandemic

Summary of the Behavioral Health Funds

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Behavioral Health Fund

- Six organizations were awarded multi-year grants in 2019, totaled $2.6 million
  - Rhode Island College
  - Rhode Island Association for Infant Mental Health
  - Care Transformation Collaborative of Rhode Island
  - Coventry Public School District
  - Clinica Esperanza
  - Bradley Hospital

COVID-19 Behavioral Health Fund

- 65 grants totaling $5.4 million were awarded to support behavioral health needs related to the pandemic
- The fund prioritized underserved communities and evidence-based best practices
- The fund was complementary to the RIF/United Way COVID-19 Response Fund

Both funds had an external advisory committee, which shaped the proposals and provided feedback on applications

Examples of Grantees from Behavioral Health Funds

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Behavioral Health Fund

- Longer term initiatives, many with focus on system change
  - RIAIMH - embedding early relational health practices and policies within systems and structures in RI that serve vulnerable infants, toddlers and their families in the child welfare system
- Through the COVID-19 pandemic, RIF has worked with grantees to provide necessary flexibility around grant workplans and objectives

COVID-19 Behavioral Health Fund

- Focus on general support for community-based behavioral health providers, including expanding telehealth capacity, including:
  - Thrive Behavioral Health
  - Newport Mental Health
- Focus on targeted support for specific subpopulations, including:
  - Dorcas International received grant focused on refugee and immigrant mental health services
  - Adoption Rhode Island received grant to support intensive behavioral health support for foster children impacted by COVID-19

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Questions?

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

Cost Growth Target Baseline Performance

RESULTS OF ANALYSIS OF 2017-2018 DATA

HEALTH INSURANCE ADVISORY COUNCIL

OCTOBER 20, 2020

RI's Cost Growth Target: Introduction

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. This states implicitly *health care spending shouldn't grow any faster than the economy*.

3.2%

2019-2022

The Cost Trends Steering Committee - A group of providers, employers, consumer representatives and insurers, convened by the Governor, committed to the target by signing a compact in December 2018.

Governor Raimondo issued an Executive Order affirming the target in February 2019.

Cost Growth Target and Employer Premiums

Q: Does this mean my company's health care costs will grow 3.2%?

A. No, it does not. The cost growth target is a ceiling for overall growth in RI of health care spending, e.g., across employer purchasers, Medicare and Medicaid.

Individual employer costs can be influenced by:

- Company-specific experience (health care utilization and population health status)
- Negotiated prices with providers
- Plan design

The target is to keep overall state cost growth at 3.2%. Spending for employer coverage is just one element of the calculation.

Cost Growth Target Baseline Analysis

- 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.

- Data were also gathered from Medicare, and from Medicaid for non-MCO expenditures.

- Data were validated by Bailit Health and the findings were peer reviewed by Gorman Actuarial.

Baseline Analysis Notes of Caution

1. The baseline performance results cannot be compared to other publicly available measurements of health spending.

2. Payer data submissions were validated, but not audited. We cannot be certain that each payer performed the calculations correctly, but have worked closely with plans to ensure their data are as accurate as possible.

3. We recently received final CY 2018 spending data and all payers have reported some differences between preliminary CY 2018 data (used in this presentation) and the final data.

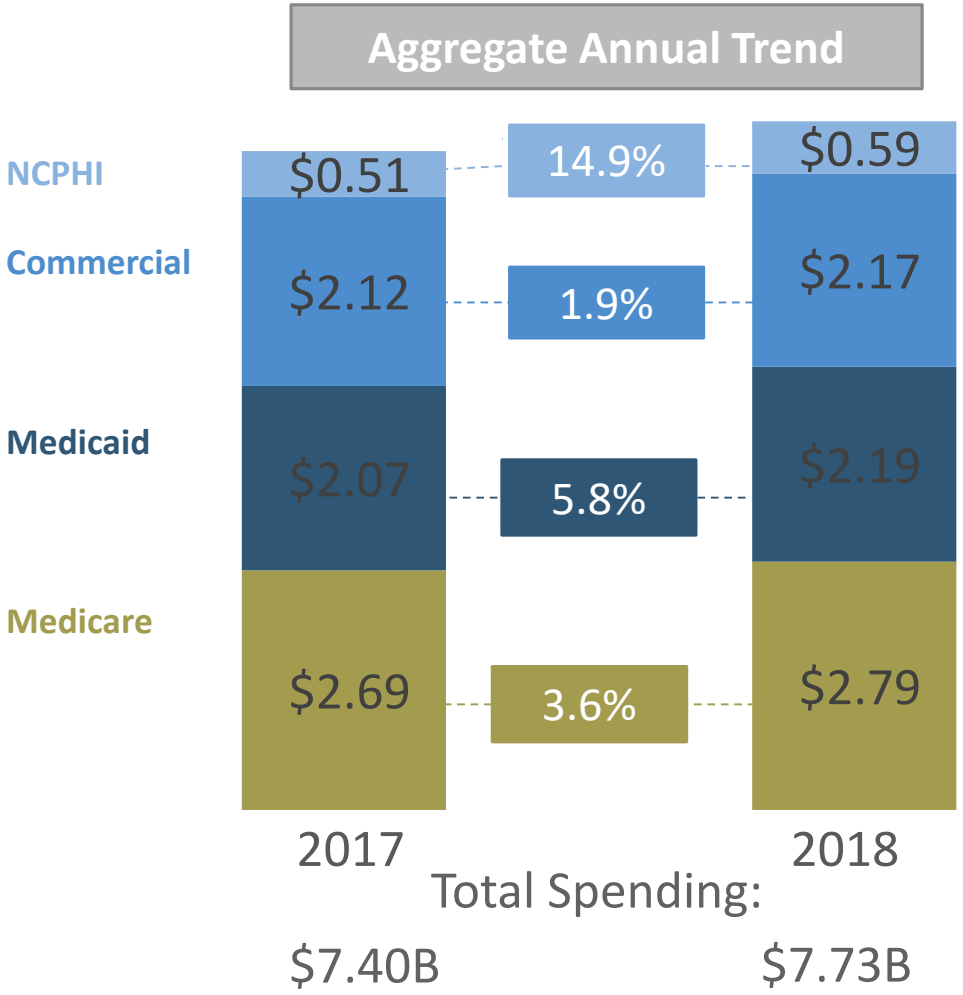
Key Definitions:

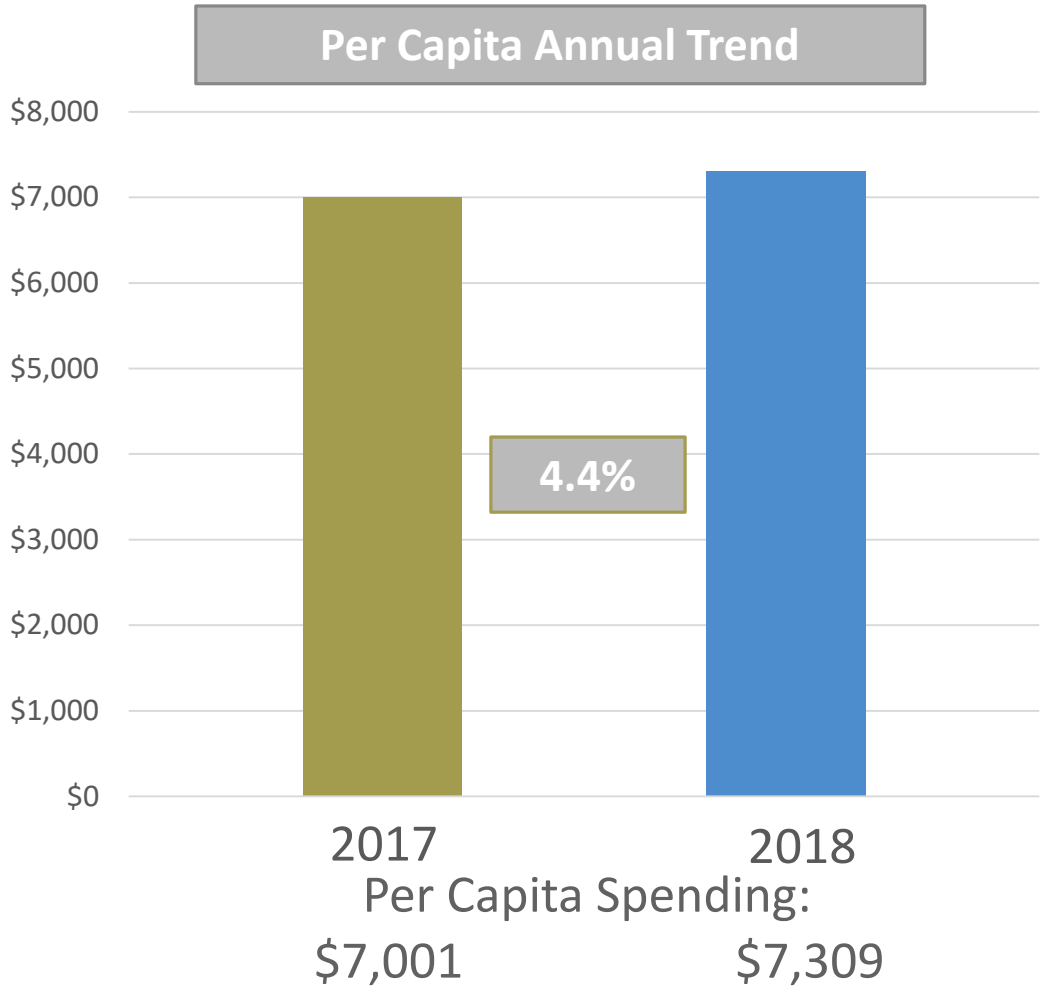
Total Medical Expense (TME): The medical expenses incurred by Rhode Island residents for all health care services by all payers reporting cost growth data to OHIC. TME is reported net of pharmacy rebates.

Net Cost of Private Health Insurance (NCHPI): Measures the cost to Rhode Island residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid managed care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers' cost of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses.

Total Health Care Expenditures (THCE): TME plus NCPHI. THCE is reported net of pharmacy rebates.

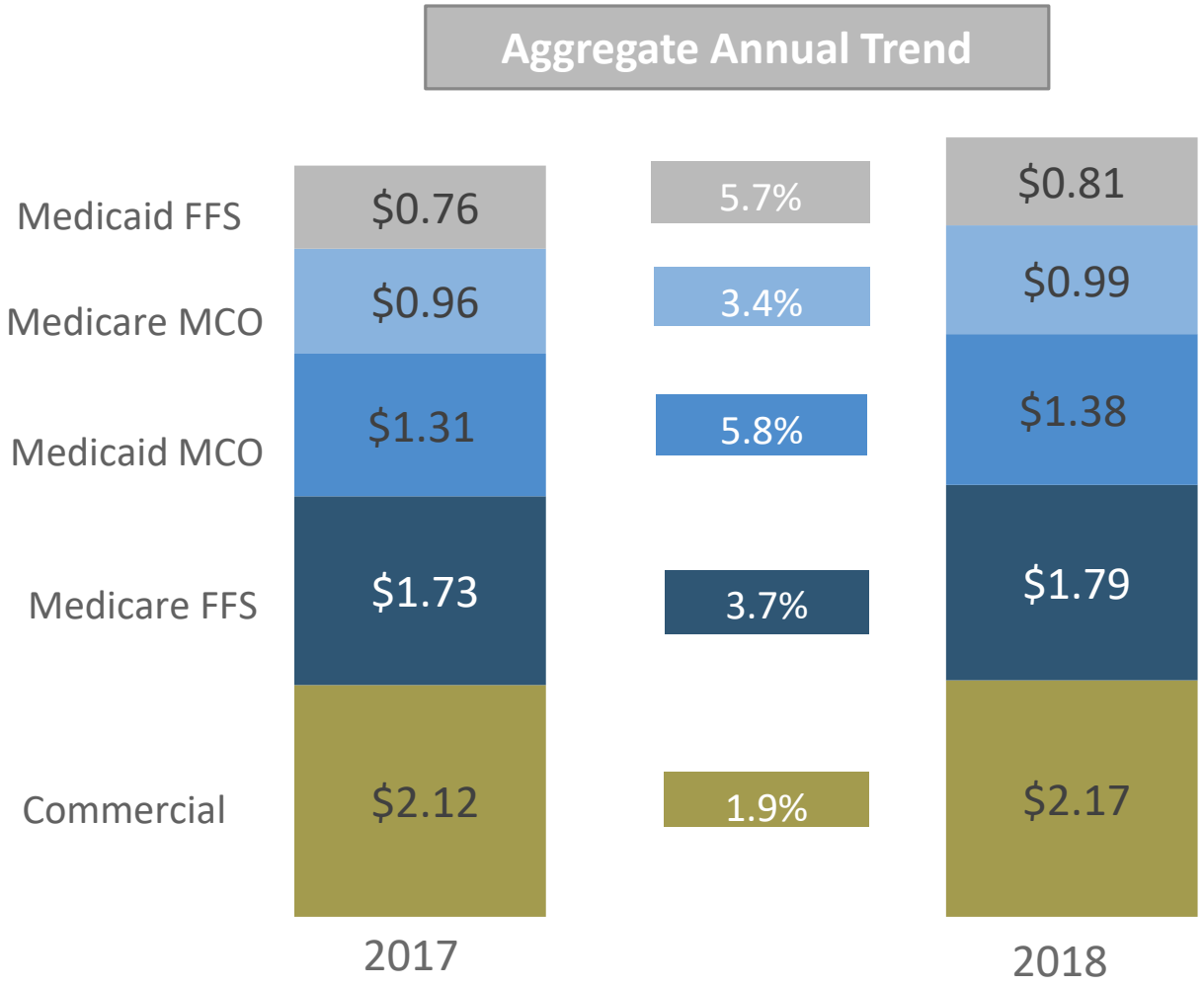
State Total Health Care Expenditures

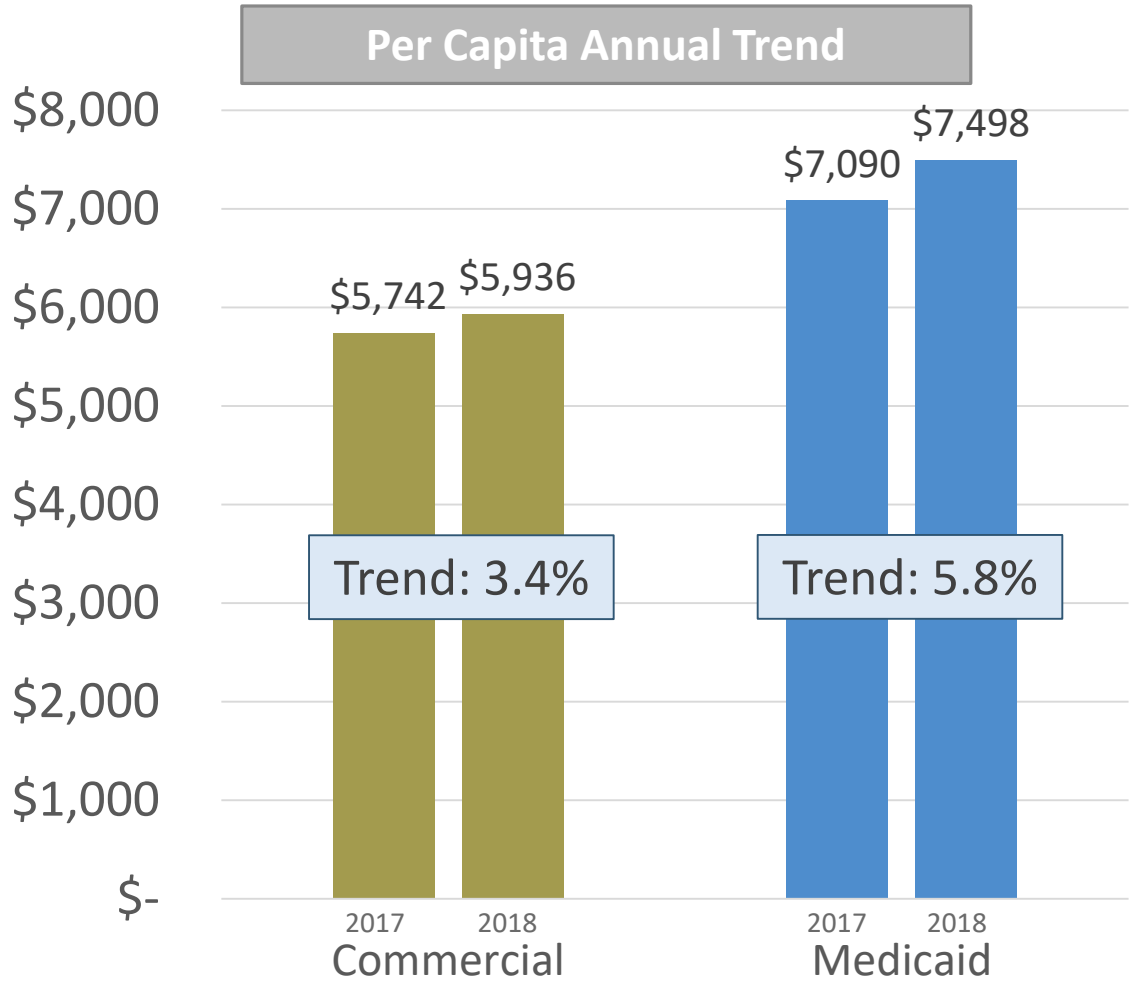




- These values are not risk-adjusted and are net of rebates.
- Medicare FFS values are gross of rebates, as the State did not receive rebate information from CMS. This slightly overstates Medicare spending.

Total Medical Expense by Market





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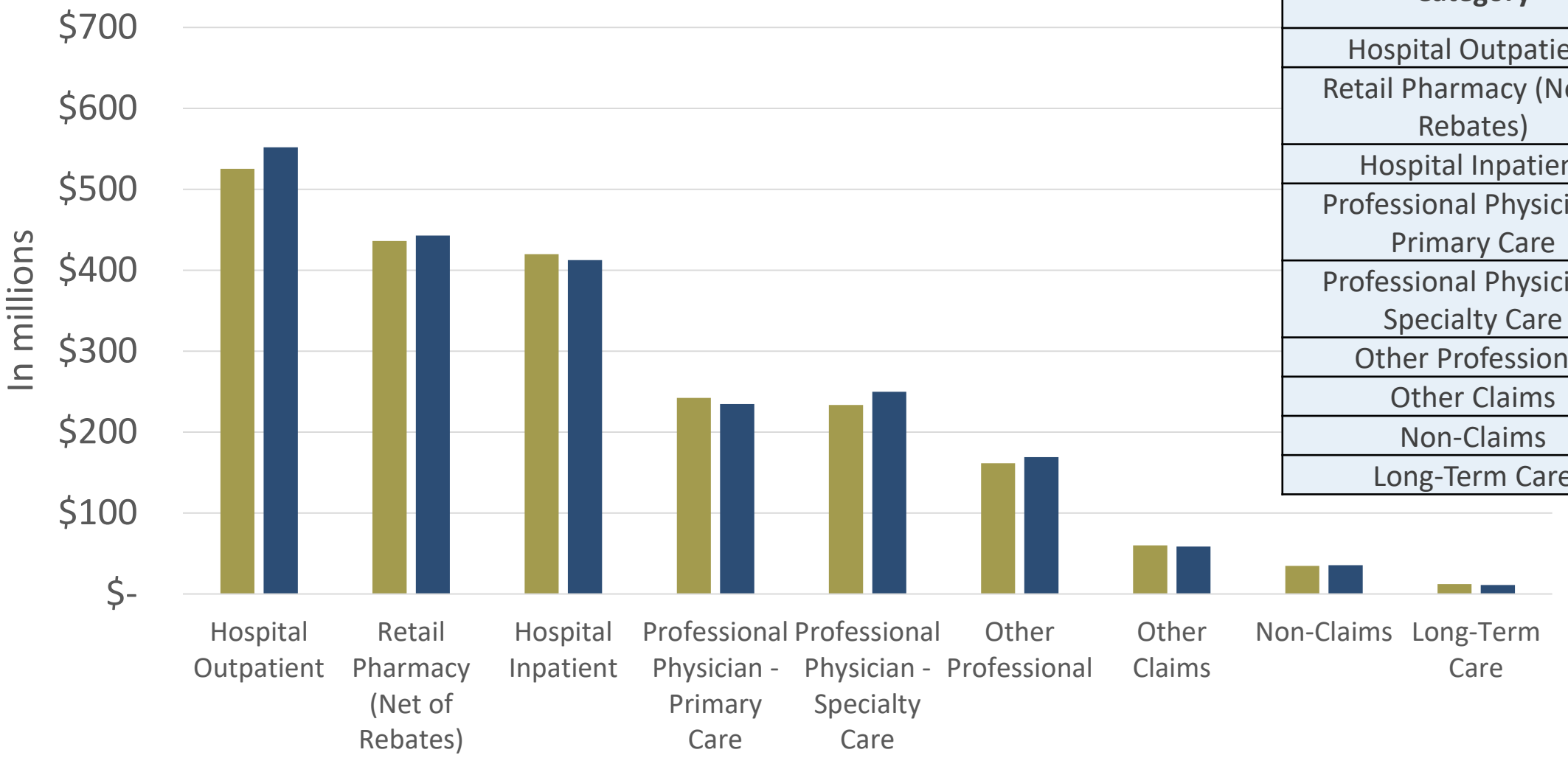
Annual Growth in Commercial Total Medical Expense by Service Category

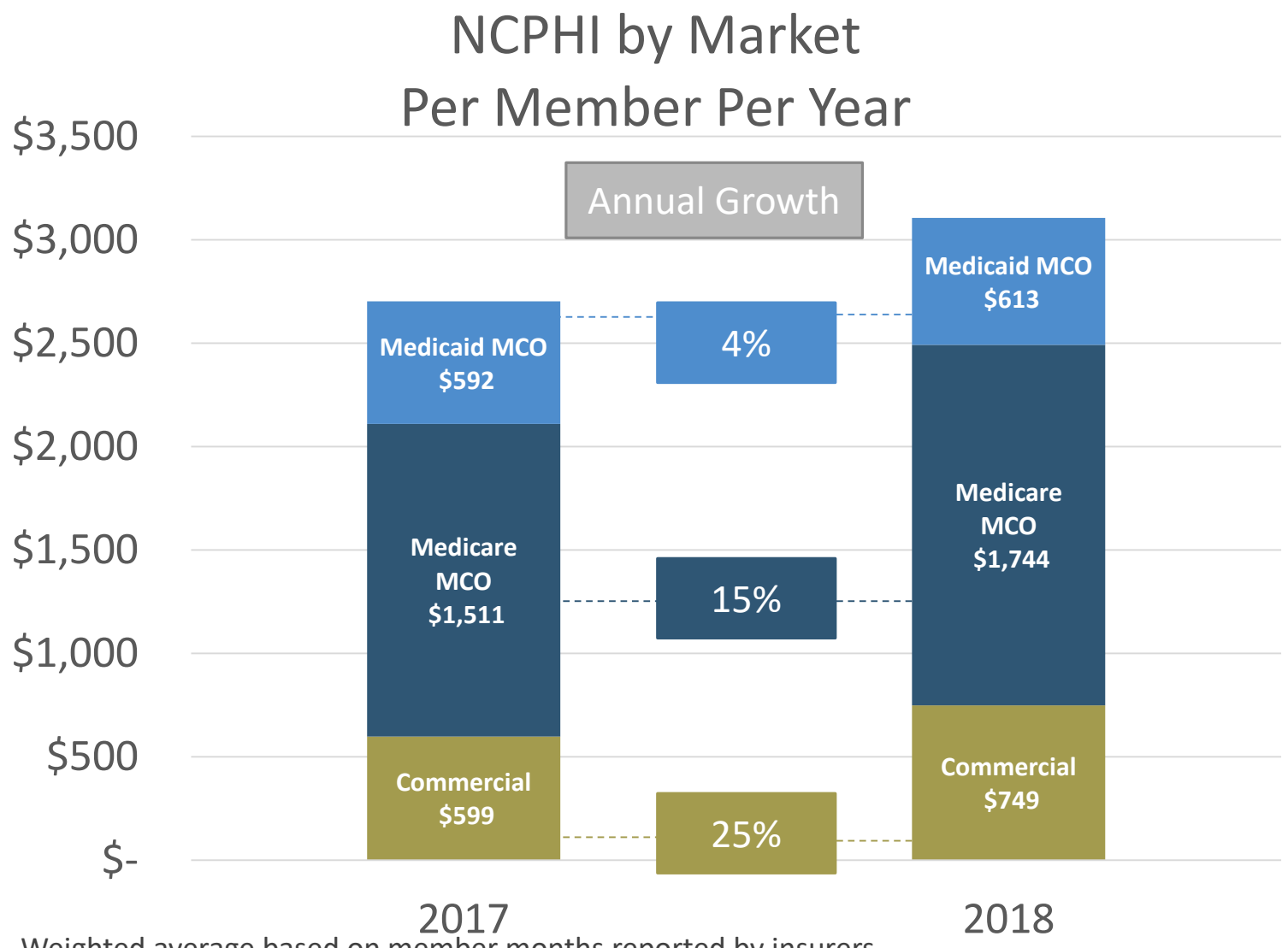


Category	2017-2018 Trend
Hospital Outpatient	5%
Retail Pharmacy (Net of Rebates)	2%
Hospital Inpatient	-2%
Professional Physician – Primary Care	-3%
Professional Physician – Specialty Care	7%
Other Professional	5%
Other Claims	-2%
Non-Claims	3%
Long-Term Care	-11%

- These values are not risk-adjusted.

THCE Trends – Net Cost of Private Health Insurance

- Medicare MCO plans have the highest admin and margin per member per year.
- Greatest overall increases in NCPHI were from the commercial individual and small group markets.
- The trend in the individual market was very high, but enrollment was low.

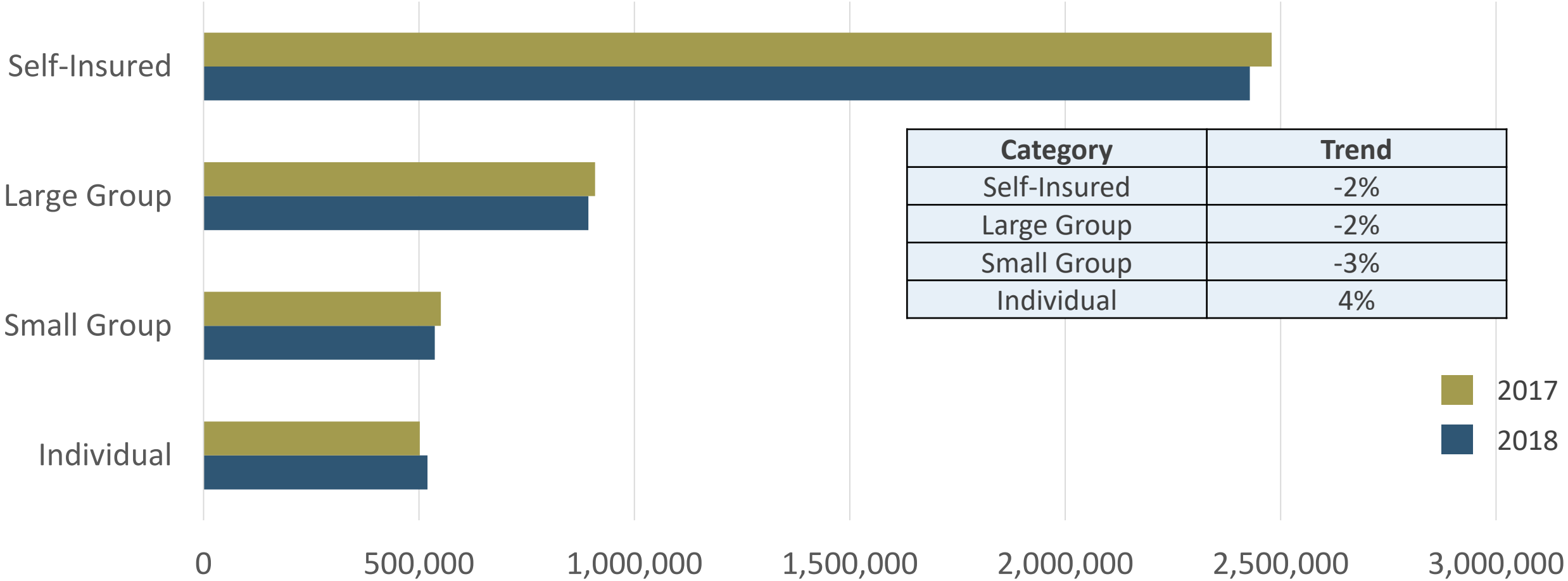


- Weighted average based on member months reported by insurers.

PMPY NCPHI Trend by Market Segment

Medicaid MCO	Medicare MCO	Self-Insured	Large Group	Small Group	Individual
4%	15%	-1%	13%	35%	169%

Commercial Market Enrollment



Category	Trend
Self-Insured	-2%
Large Group	-2%
Small Group	-3%
Individual	4%

Data are presented in member months and represent Rhode Island residents only

Follow-up Questions

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HIAC Update: OHIC's Telemedicine Advisory Group— Health Equity Considerations

OCTOBER 20, 2020

Background: Framework for RI Workgroup

Coverage and Access

Increasing the coverage of telemedicine services and removing barriers to access.

Payment and Program Integrity

Payment parity and safeguards against waste fraud and abuse.

Security, Privacy and Confidentiality

Security, privacy and confidentiality of telemedicine.

Performance Measurement

Ways to measure quality, outcomes and the cost of telemedicine now and in the future.

For each of these issue areas the group will:

- Review RI existing legislation, temporary emergency policies, and language in the proposed budget article;
- Review work in other states; and
- Goal: develop consensus recommendations

Coverage and Access

Question: How to leverage telemedicine to promote health equity and reduce disparities in care

- While telemedicine can increase access to care, we want to be sure that it does not exacerbate existing disparities in care.
- Some providers report that they have seen early signs of disparities in access to care delivered through telemedicine.
- 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
  - i.e. racial/ethnic minorities, people who live in rural areas, people with limited English proficiency, people with low literacy, people who are low income
- 26.3% of Medicare beneficiaries lacked digital access at home, making it unlikely that they could have telemedicine video visits
  - Those who lacked digital access were more likely to be low socioeconomic status, over age 85, or people of color

Sources: (1) https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2768771 [jamanetwork.com]; (2) (2) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7428456/ [ncbi.nlm.nih.gov]

Digital Divide Can Exacerbate Existing Disparities

Absence of Technology

- In households headed by a person 65 and older:
- More than one third do not have a desktop or a laptop
- More than 50% do not have a smartphone

Digital Literacy

- 52 million Americans do not know how to use a computer effectively
- Those who lack digital literacy tend to be older, less educated, and from communities of color

Reliable Internet Coverage

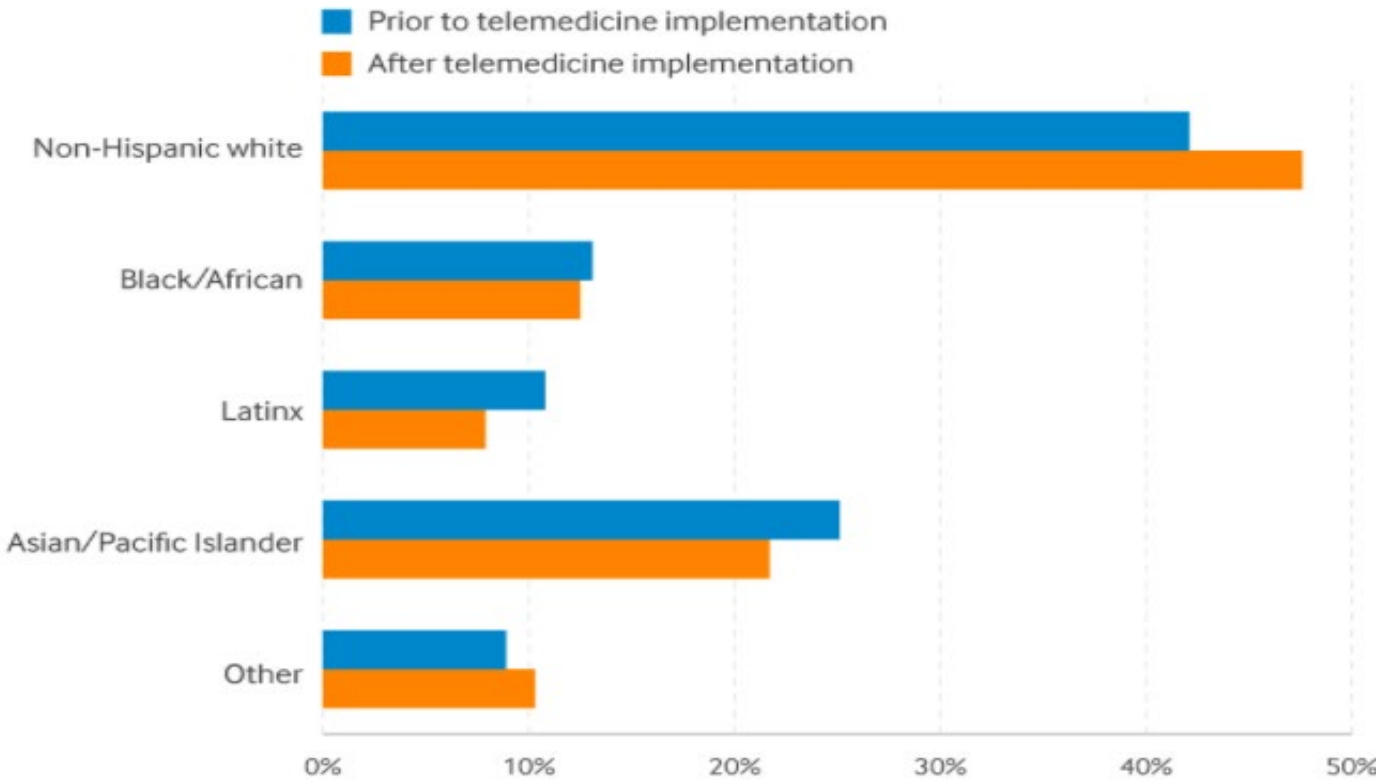
- Nationally, 79% of Whites had home broadband, vs. only 61% of Hispanics and 66% of Blacks
- In RI, 98.5% have access to broadband and 88.5% have access to a low-priced internet plan

Sources: (1) Velasquez, D and Mehrota, A. "Ensuring the Growth of Telehealth During COVID-19 Does Not Exacerbate Disparities in Care." *Health Affairs Blog*. May 8, 2020; (2) www.broadbandnow.com/Rhode-Island; (3) https://www.pewresearch.org/internet/fact-sheet/internet-broadband/

Coverage and Access

Question: How to leverage telemedicine to promote health equity and reduce disparities in care

Patient Visits by Race/Ethnicity Before and After Telemedicine Scale-Up



- 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

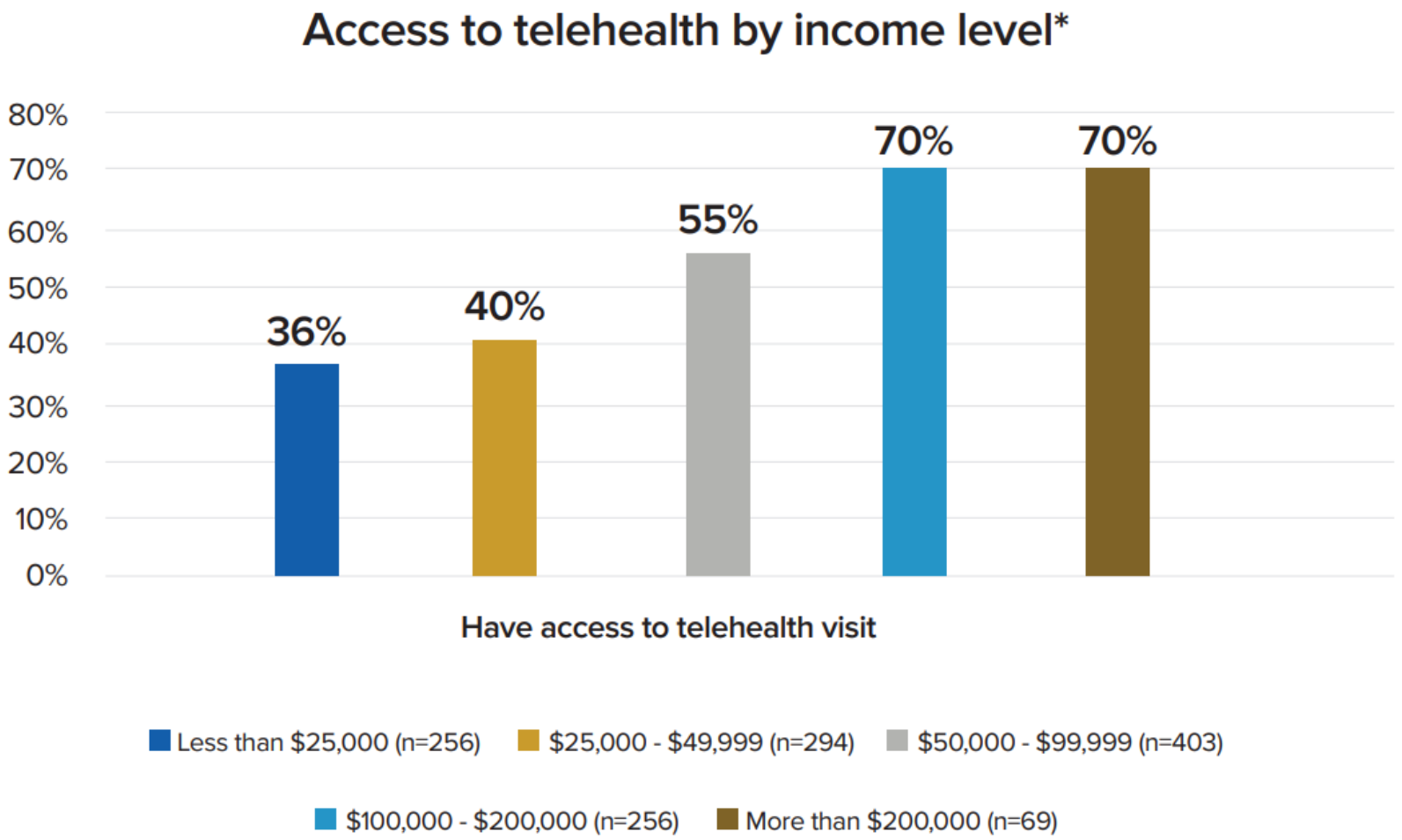
SOURCES: Nouri et al, "Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic," NEJM Catalyst Commentary, May 4, 2020.

Coverage and Access

Question: How to leverage telemedicine to promote health equity and reduce disparities in care

Higher income individuals were more likely to have access to telehealth services

- Only 36% of respondents who make less than $25k had access to a telehealth visit
- 70% of respondents with incomes above $100,000 had access to a telehealth visit



SOURCE: Sage Growth/Blackbook Research, "As the Country Reopens Safety Concerns Rise," May 11, 2020.

Health Equity Preliminary Recommendations to Date

- The Subcommittee identified several opportunities for ensuring health equity and reducing disparities in access to telemedicine services:
  - Explore opportunities for partnership for sharing of lessons learned with other agencies, such as education, that are also working to address access to broadband technology and equipment, as well as digital literacy, during the pandemic
  - Add telemedicine access to network adequacy standards.
  - Identify a public/private initiative to support telemedicine use in the community, such as a location for individuals to hold telehealth visits, a lending library for technology, or repurposing donated equipment.
  - Utilize the existing workforce who go into homes (i.e. community health workers, peer recovery specialists, home health aides, etc.) to assist in digital training.
  - Provide statewide access to broadband or hotspots for municipal areas that do not have it.
- The Subcommittee will revisit and reconsider health equity topics at the November 12 meeting

PUBLIC COMMENT