State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
November 16, 2021, 4:30 P.M. to 5:30 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 Patrick Tigue, Co-Chair Stephen Boyle, Al Charbonneau, David Katseff, Laurie-Marie Pisciotta, Daniel Moynihan, Shamus Durac, Amy Nunn, Eugenio Fernandez, Lawrence Wilson, Mark Jacobs, David Feeney, Sandra Victorino, Cori Chandler

State of Rhode Island Office of the Health Insurance Commissioner Staff
Cory King

Not in Attendance
Catherine Cummings, Hub Brennan

Minutes
1. Welcome, Introductions, and Review of October Meeting Minutes
Steve Boyle called the meeting to order. After introductions, Steve asked for a motion to accept the October meeting minutes. Teresa Paiva Weed noted that her name was not listed in the attendance – after that correction, the minutes were approved.

2. Health Insurance Premium Cost Drivers Series: Part II
Commissioner Tigue commented that this topic is the second part of a three-part presentation. This presentation was created using all of the data our office collects through our annual rate filing process. There is a lot of useful data sent to us during that process that we believe is useful beyond the rate review decision process and this year we decided to analyze that information to highlight the key drivers of health insurance premiums in Rhode Island.

Cory King explained that during the last meeting we reviewed trends in enrollment and demographics within the fully insured market. There were two follow-up requests from HIAC members – Steve asked if the age distribution in the Individual and Small group markets is similar to the Large group market, the answer is yes. The other follow-up question came from David Katseff – he requested a breakdown of Rhode Islanders by their insurance type, so we have provided that breakdown here.

Steve Boyle commented that the number of insured in these groups is going down, do we know where these people are going? Cory commented that in this instance it could be that the size of the market is declining. There has not been a 1-1 reduction from fully insured, to an increase in self-insured – the limitation of this data is that it does not include Aetna or Cigna, both of which have self-insured accounts. Another possibility is that there may be Rhode Islanders who live here but work out of state and get their insurance from out of state.

Cory continued with the presentation, noting that total earned premium per member, per month increased in 2019, (by 4.1%) but in 2020 it remained relatively flat. When you look at these earned premium trends, they are distinct from the approved rates that we ultimately issue each year. With rate review you are looking at a status population and assuming no change in plan selection from year to year, and you are also not accounting for terminated business, and new business that comes out of the insurer book. Approved rate changes will differ from earned premium changes for various reasons:

- *Benefit Buy Down* - Approved rate changes assumes no change in plan design compared to the prior year. Earned premium reflects enrollees switching plans from year to year, typically to a lower costing plan.
- *Demographic Shifts* - Approved rate changes reflect static populations. Earned premium changes reflect the changing age of the population.
- *Market Shifts* - Approved rate changes do not reflect any shifting enrollment among insurers while earned premium changes will include this. This includes shifts due to new and terminated business.
- *2020 COVID Premium Credits* - Some insurers provided premium credits to individuals and groups due to the impact of COVID. This is included in the earned premium change but not the approved rate changes.

Allowed claims reflect the total amount paid for a service, inclusive of what the insurance company pays and what the member pays out of pocket in terms of their deductible and any copays applied to the service. Something interesting is that one might expect the allowed claims to trend down in every market (individual, small, and large) in 2020, but in large group it was essentially flat. Commissioner Tigue commented that we have a high degree of confidence in the data and one of the questions we have is why it appears that utilization was depressed by COVID much more significantly by individual and small group members, than large group members.

In 2020 there was a significant reduction in consumer cost-sharing burden – part of the reason for this is that certain types of services that would have cost-sharing associated with them were forgone during that year. Those are the types of services that would have a deductible, etc. The other factor is that many health plans carried out the shift to telemedicine without cost-sharing.

Incurred claims are important from a rate review perspective because that defines the revenue target that the insurers are trying to meet. In 2019, Incurred Claims PMPM trends increased 4.5% in each of the group markets and slightly more in total at 5.0%. The individual market experienced a 7.7% increase in 2019.

Cory continued, noting that we have been looking at total expenses – payment for all medical services, because we want to get a picture of the breakdown of cost into various service categories. The reason we do that is because we are interested in where regulations might be able to be tailored to improve affordability.

Teresa Paiva Weed commented that part of the reason hospital costs are higher currently is because labor costs are significantly higher than usual. Additionally, length of stay is higher. Cory responded that he doesn't expect to see any COVID-19 suppression of utilization – in fact, you could see an increase of claims costs into 2021.

Al Charbonneau commented that if we are thinking of terms of affordability, we should not make decisions based off of what happened during COVID.COVID also points to the fact that the hospitals

were not really prepared for dealing with this kind of emergency and if you look at hospital costs leading up to COVID but before it hit, there is a growth of overhead, growth of non-reimbursable costs in hospitals across the country. With respect to this data, it is important, but we ought to look at this in terms of tackling the major cost drivers.

Mark Jacobs commented that he read recently that 50% of the proposed increase in Medicare premiums for 2021 are dur to the new Alzheimer's drug, and although that probably doesn't apply as much to the commercial population there may still be some in that group that are candidates for this drug. The drug costs $56,000 per year. Additionally, to Al's point, to the extent that we can start to have primary care providers control the flow of patients to the appropriate specialists at the right time instead of self-referrals like we often have now, that would help to control costs.

Sandra Victorino asked, how do we take that into consideration when thinking of diverse populations? BIPOC populations are often the population to self-refer because they are not being listened to by their primary care doctors. When we are taking that into consideration, we need to look at the full picture – as we are building systems, we have to also acknowledge was has happened in the past.

When we say that spending on health care is the key-driver of premiums, we mean that because they are the most significant portion of that premium. There is an administrative component baked into premiums, and they often price into rates a charge for contributions to reserves but spending on health care is the largest component.

Commissioner Tigue commented that health insurance is expensive because health care is expensive. It is not to say that we do not scrutinize insurer revenue and profit costs, we do that, but to really address affordability we need to address the cost drivers of the health care aspect of premiums.

David Katseff asked if the total premium listed for the individual market is net premium, or the actual premium? Many of the plans on the individual market are subsidized, does this premium on slide 20 represent those subsidies. Cory commented that it does include those subsidies.

Steve Boyle asked if there is any way to segregate the actual impact of COVID versus the baseline trend in health care expenses? If prices were rising already, how do we measure that against COVID? Teresa Paiva Weed commented that if you look at the discharge data you can see the increases in labor costs, length of stay, etc. The increased labor costs will not go away after COVID.

3. **Affordability Update**

Commissioner Tigue commented that OHIC will be putting out an advanced notice of proposed rulemaking for the next generation of Affordability Standards in the next few weeks. This will highlight our current thought process after connecting with nearly 30 groups on the subject. We welcome all comments from the council and the public about the proposed amendments to the Affordability Standards.

4. **RIREACH Consumer Update**

Shamus Durac commented that RIPIN has been out in the community doing events pertaining to Open Enrollment. So far this year there has not been an influx in complaints or concerns about Open Enrollment. In terms of trends there have been some calls related to consumers getting bills from a doctor for telemedicine appointments, when in the past those interactions were not billed.

5. **Other Business**
   Amy Nunn asked if we would consider a Zoom dial-in? Cory responded that his reading of the open meetings act is that members of a public body can only participate virtually if they are active-duty military or if they have a disability. As a member of a public body, we cannot unfortunately allow zoom participation. Commissioner Tigue responded that to the maximum flexibility of law we would like to allow that, but unfortunately as we read law, we cannot do it.

   Lawrence Wilson commented, whether it is telemedicine, or open enrollment, etc., are you monitoring demographic trends? Shamus replied yes, RIPIN has spent a large amount of time recently collecting demographic data. RIPIN is hoping to be able to accurately state who they are serving, collectively, soon as they continue to collect more demographic data.

   Sandra Victorino asked how we know consumers are being connected with primary care physicians? Shamus replied that RIPIN sometimes works with the managed care organizations directly to assist with that. Mark Jacobs commented that when a provider signs a contract with one of the insurers, it obligates that provider to state whether their panel is open or not. Providers cannot cherry-pick patients, they have to report to the insurer if they do not have availability. Sandra Victorino commented that right now there is simply a lack of providers that have availability – if we don't have enough primary care physicians it leads to gaps in treatment.

   Laurie-Marie Pisciotta commented that the Mental Health Association of RI is at the beginning of a large campaign to persuade the state that we need greater investment in behavioral health care. We will be doing a lot of community organizing and advocacy around that, so if anyone if willing to join or become thought-partners with us on that event you are more than welcome.

6. **Public Comment**
   There was no public comment.

7. **Adjournment –** The meeting was adjourned at 5:39 pm