State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
October 16, 2018, 4:30 P.M. to 6:00 P.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue
Cranston, RI 02920

Attendance

Members

Co-Chair Commissioner Marie Ganim, Co-Chair Stephen Boyle, Ruth Feder, Teresa Paiva Weed, Sam Salganik, David Katseff, Karl Brother, Al Charbonneau, Vivian Weisman, Daniel Moynihan

Issuers

Gus Manocchia, Blue Cross & Blue Shield of RI
Carolyn Rush, Neighborhood Health Plan of RI
Lauren Conway, UnitedHealthcare

State of Rhode Island Office of the Health Insurance Commissioner Staff

Not in Attendance

David Feeney, Deb O'Brien, Hub Brennan

Minutes

1. Welcome and Review of September Meeting Minutes

Commissioner Ganim called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance.

The minutes from the September 25, 2018 HIAC meeting were accepted unanimously with the following change: Ruth Feder clarified that Mental Health America joined litigation in Washington regarding newly enacted federal rules on short term health plans, it did not file suit.

2. RIREACH Consumer Update

Sam Salganik provided an update on RIREACH – volume is relatively steady with approximately 200 new clients in September, 1500 total documented interactions. He noted that the September-October period is typically the "calm before the storm" of open enrollment period at year end – not just HSRI's, but also open enrollment for many private companies and organizations as well. He reported January - June customer satisfaction ratings: of 70 total surveys, 60 came back rating RIREACH 10/10; 5 rated 9/10; and eight rated 8/10 or lower. RIREACH has saved consumers $1.6 million so far in 2018.

Commissioner Ganim asked if RIREACH had gotten any calls from consumers receiving surprise medical bills. Sam said the few they have received in the last year or so were either related to a self-insured plan or were out of state providers and would not have been addressed by legislation considered in the General Assembly earlier this year.

3. Discussion on CTC-RI's Integrated Behavioral Health Primary Care Pilot

Deb Hurwitz of the Care Transformation Collaborative of Rhode Island (CTC-RI) gave a presentation to the HIAC on their Integrated Behavioral Health Primary Care pilot program.

The program emerged after a pre-pilot that was funded by Tufts Health Plan in 2014-2015. CTC primary care practices were having difficulty reducing ED visits among patients with behavioral health/substance use disorders. CTC-RI convened a working group of primary care and behavioral health providers and others and developed a business caser for integrating behavioral health into the primary care setting. Using this plan, CTC-RI secured funding for a 3-year pilot from partners including the Rhode Island Foundation, Tufts Health Plan, and the State of Rhode Island's SIM project.

The pilot included two cohorts of 5 practices each from across the state. The program included universal screening for depression, anxiety and substance use disorder; as well as behavioral health training and supports in the primary care setting.

Findings: Providers and staff had predominantly positive perceptions of IBH. Practices saw reduced ED use and increased treatment compliance. Total medical and pharmacy costs of care among the participating cohort were lower on a per member per month basis relative to CTC practices not participating in the IBH program.

ED visit data presented showed a decline, but available data ended at December 2017. Teresa Paiva Weed predicted that ED use would significantly increase after this period based on information she had as president of the Hospital Association of Rhode Island. She cited the closure of Memorial Hospital on December 31, 2017 and the closure of the Emmanuel House substance use diversion program in May of 2018 as drivers of the increase.

Ruth Feder asked if this IBH program would interact with the new BH Link program set to begin the following month. Deb replied that it likely could, and that all providers participating in the IBH program would be made aware of the availability of BH Link as a resource.

Regarding patient behavioral health screenings, David Katseff shared his experience of being as to complete a behavioral health questionnaire at his primary care provider's office but receiving no explanation as to why it was given to him, he said this happened multiple times. Ruth commented that her experience working with the community informed her that many patients are reluctant to complete such screening questionnaires due to confidentiality concerns – these patients may not be aware of their rights under HIPAA. Additional patient/consumer education was recommended.

Next steps for the IBH program include the release of a quantitative study by Brown University, findings and recommendations published by CTC-RI. CTC-RI is also working with OHIC on a pilot alternative payment model that includes IBH in primary care.

4. Discussion on Low-Value Care

Council member Al Charbonneau, Executive Director of the Rhode Island Business Group on Health (RIBGH), gave a presentation on low-value care.

Low-value care was defined as patient care that provides no net benefit in specific patient care scenarios. According to the Institute of Medicine in 2010 low-value care accounted for $750 billion in annual excess health care spending. Unnecessary medical services were cited as the largest contributor to excessive low-value care spending, with a few examples provided: it was estimated that 30% of

inpatient antimicrobial therapy, 26% of advanced imaging, and 12% of acute percutaneous coronary interventions were unnecessary and not beneficial to patients, thus meeting the definition of low-value care.

Al presented data from a survey of AMA members ("Overtreatment in the United States"); providers responding to the survey estimated 25% of tests, 22% of prescriptions, and 20% of overall medical care provided was unnecessary. Reasons doctors gave for engaging in unnecessary care included fear of malpractice (84%), patient pressure/request (59%), difficulty accessing patient records (38%), and fee for service (71%).

In Rhode Island, the RIBGH has partnered with many employers and the State of Rhode Island in participating in Consumers' Union's "Choosing Wisely" initiative to educate patients/consumers about low-value care, what questions to ask their doctor, and ways to avoid unnecessary medical care.

RIBGH's next steps on low-value care include assessing the amount of low-value care in Rhode Island, creating a pathway forward, and organizing employers' support for change.

Sam asked how the United States' numbers on low-value care compared to other countries. Al said that low-value care was a problem all over the world, except perhaps for in economically depressed/developing nations where access to any kind of care is difficult. Al said there was a growing argument that low-value care is a bigger problem in more affluent countries, adding that it is probably a bigger problem in the US but that all OECD nations struggled with it.

Teresa mentioned generational differences in the way patients interact with their doctors – many older Americans grew up with a "Marcus Welby" mentality of following doctors' orders without question; now, it is more important for patients to become more engaged in their medical care.

Al suggested that changing the payment system would be a solution to excessive spending on unnecessary care, as providers operating under capitated/risk-based models would be incentivized to engage their patients more and avoid low-value care.

Gus Manocchia of BCBSRI agreed, saying the best way to reduce low-value care is to incentivize doctors financially with the right kinds of contracts and payment methodologies to make them interested in being concerned about cost.

5. Public Comment

Deb Hurwitz commented that in addition to the patients and doctors, she got a lot out of the low-value care conversation about employers and their value-based insurance designs saying this was another important key. As employers identify low-value targets and use the information in their insurance designs, it leads to more educated consumers. She said she loved the idea of all stakeholders having a role to play.

Next Meeting

The next meeting of the Health Insurance Advisory Council will be Tuesday, November 20, 2018, from 4:30 – 6:00 PM at the State of Rhode Island Department of Labor and Training, 1511 Pontiac Avenue, Building 73-1, Cranston, RI, 02920-4407.