State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
November 20, 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, Al Charbonneau, Teresa Paiva-Weed, Sam Salganik, Vivian Weisman, David Feeney, Ruth Feder, David Katseff, Deb O'Brien, Daniel Moyniham, Karl Brother

Insurers
Tinisha Richards, United Healthcare
Liz McClain, Neighborhood Health Plan of RI

Not in Attendance
Hub Brennan

Minutes

1. Welcome and Review of October Meeting Minutes

Stephen Boyle called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance. Stephen mentioned that there are parties who have expressed interest in joining HIAC. Karl Brother asked if there is a statutory limit on how long one can serve as part of the council, Commissioner Marie Ganim said they would further address that at the next meeting. HIAC would like to maintain a balance between the business community and the consumer community.

The minutes from the October 16, 2018 HIAC meeting were accepted unanimously.

2. RIREACH Consumer Update

Sam Salganik provided an update on RIREACH; volume is steady, they continue to save consumers money, averaging 200-250 new cases per month, last month they saved consumers about $50,000. In January they started tracking their data with a new system, they'll be analyzing the data to prepare their new annual reports.

Sam shared two success stories he felt were worth highlighting.

3. OHIC Office Updates

a. MOU with Medicaid
OHIC and EOHHS developed an MOU, in which Medicaid is going to fund OHIC for a given amount of money over three years to build a program which will oversee provider financials. OHIC will be delegated the responsibilities from Medicaid. OHIC will be drafting and introducing legislation this upcoming session to grant the office the authority

to do such an analysis across all lines of business. OHIC's program will be modeled like that of Massachusetts. Risk certifications will certify that providers could bare a certain number of financial risks. There will be guidelines, an application process, and standards for OHIC's review.

Daniel Moynihan asked if OHIC is supplanting what Medicaid had been doing for itself? Cory explained that there is currently a void in oversight; as no one is currently performing this task. Daniel questioned how Medicaid planned to fund this effort, when the federal subsidy for Medicaid has been in decline?

Commissioner Marie Ganim stated that this effort is tied to a three-year extra that Medicaid received special approval for to transform the healthcare system, it is not much money, it will save Medicaid in the long term. There will be cost savings associated with this effort.

David Feeney recapped his understanding of the MOU; OHIC is going to develop a risk certification tool, that organizations will have to submit annually; to certify that they can meet whatever the financial criteria are established to show that they could sustain a financial impact. Cory agreed with his analysis and provided different examples of how it might be done; from less resource intensive to greater; whether by requiring the provider to attest to being able to handle the impact, requiring financial statements or actuarial letters, or by approval of contract reviews.

b. Clarification of OHIC Powers & Duties Regulation
OHIC Regulation 2 was updated and re-codified to: 230-RICR-20-30-4.10. The section that addressed hospital contracting requirements specifically pretraining to rate caps had been clarified.

c. Cost Trends Projects
Commissioner Marie Ganim discussed the Governor's project to set a target for all the health care spending for the State. The Governor was able to get funding so that Brown University may work with EOHHS and OHIC with the Peterson Center. A Steering Committee was formed, it is co-chaired by herself, representing the State, Kim Keck, representing the insurance community, and Al Kurose, representing primary care providers. The group is composed of providers, insurers, individuals from the business communities and community organizations. The group is advising the state on how to move forward. Commissioner read the vision of the Cost Trends Project; "to provide Rhode Island Citizens with high-quality, affordable healthcare through greater transparency of healthcare performance and increased accountability by State laws." The goals are to reduce growth in healthcare costs by developing a cost growth target and providing transparency regarding healthcare performance. Another goal is to develop a deeper understanding of what's driving our costs and variations in expenditures; we are

using the all-payer claims database and Brown University is doing the analysis. Lastly, creating a sustainability plan.

Vivian Weisman asked how the concept was developed that healthcare costs should increase as fast as everything else? Healthcare has been going up much faster than everything else and food costs have soared, does this mean that healthcare would continue to rise as well; to keep up with the food prices going up?

Commissioner Ganim said that the target is a way to measure how we are doing, she expressed that there are several indicators they could have used. Stephen explained that they're measuring State domestic products, not consumer products.

Teresa stated that the hospitals had expressed concern because they have a rate cap that has been established differently, then this aspirational growth target. In other states, they haven't had hospitals actively participate. In MA, they have examples of needing to allow leeway in the opposite direction for pharmaceutical spikes, because there was almost an assumption that healthcare costs are growing much faster than everything else. The hospitals have been a little resistant to the standard, but we all agreed on the positive, that DE and MA are using this, and if we are going to have a standard on a national level, the benefit of the standard is that; the standard.

Sam mentioned that his concern is the focus on cost without looking at the quality of care.

d. OHIC/HIAC Annual Report
Commissioner Ganim thanked everyone for commenting on the annual report from last year. She asked the group to notify her if there is anything they would like to see included on future reports.

4. Affordability Standards Evaluation Preview

It was decided in 2014 that an evaluation/assessment of the Affordability Standards would be conducted in the calendar year 2018. The evaluation is currently being reviewed by OHIC staff. The original goals of the Affordable Standards included the following; consumers of health insurance have an interest in stable, predictable, affordable rates for high quality, cost-efficient health insurance products. Cory reviewed some of the outcome metrics from a systems perspective on whether they're being met:

1. Improved primary care supply, measured by the total number of primary care providers, and by the percentage of physicians identified as primary care providers.
2. Reduced incidence of hospitalizations for ambulatory care-sensitive conditions, and of re-hospitalizations.
3. Reduced incidence of emergency room visits for ambulatory care-sensitive conditions.

4. Reduced rates of premium increase for fully insured, commercial health insurance.

Increased quality of care and increased access to care could also be included.

Deb O'Brien wanted to discuss point number three. If one goes to the emergency room, and you're admitted, it is likely not an ambulatory care sensitive condition. Cory explained that NYU created an algorithm for flagging emergency room visits that were considered sensitive condition. Deb expressed that if you are hospitalized, chances are you've already gone above that, it's more acute. Cory expressed that they've been given a set of codes to differentiate. The idea is that the hospitalization would have been avoidable had the patient received proper and timely access to care.

Cory discussed the evaluation questions. How well have insurers complied with Affordability Standards, including the performance standards set in the annual Care Transformation and Alternative Payment Model Plans? As a sub-component, to be discussed at a future meeting, there has been an in-depth assessment of compliance with the hospitals and ACO contracting requirements, and an audit of contracts to determine compliance. There has been an evaluation and audit of each insurer to be discussed with them.

Cory reviewed the second question, "how do RI commercial insurance premiums compare to those of regional states and what has been the growth in health insurance premiums since the implementation of the Affordability Standards relative to external benchmarks?" The group had seen some of this analysis before, as they previously shared inter-state comparisons of plan designs. They pulled data from CMS, and medical expenditure panel survey, and looked at other data and studies that compared cost trends. They looked at one done by Harvard which found evidence for trend abatement during the period of Affordability Standards, and that our premiums are a little lower.

Cory continued to review the evaluation questions.

Al Charbonneau asked about the improvement of clinical processes; how could it be stated that the Affordability Standards have improved clinical outcomes?

Cory explained that the evaluation looked at the correlation over time, not for causation. Has there been an uptick on the quality of care? The standards had done a few things, which included adding money into primary care. It won't be stated that OHIC lead to an increase in clinical outcomes.

Teresa said the regulation required all the measures to be incorporated into the contracts. As a part of the negotiations; quality measures made up 50% of the contract, it's fair to suggest that there is a quality factor.

Al said he was thinking of this process from a CTC point of view. Cory mentioned this is not to take credit from those initiatives.

Cory continued to address the evaluation. Most of the quantitative work was done by Amy Lishko, Associate Professor of Public Health and Community Investment at Tufts, who also works for Bailit and is a researcher. Richard Kultzky, an independent entity; performed the qualitative evaluation and held the stakeholder interviews. Bailit completed the compliance evaluation and the audit of contracting.

The group reviewed two examples in which the Affordability Standards produced the intended outcome and one in which they didn't. The first was primary care spending; the standards successfully increased resources to primary care; which had the effect of supporting the PCMH initiative, significant practice transformations in the state have put us in the position where ACOs could inherit a sound primary care infrastructure. Regarding primary care supply; we wanted to increase supply and access. The data that looked at primary care physicians per 100,000 population, from 2008 – 2015 did not tell a great story; in all the New England states the rate increased, the rate in Rhode Island only increased +7.16 percent. However, Rhode Island had one of the highest rates to begin with, but this measured whether the supply had *increased*; which only included physicians and did not include nurse practitioners. The group requested clarification on who's included in the supply; Cory stated that he would research it.

Sam reviewed the previous slide; he highlighted that new funding went to things other than physicians, or existing physicians, and risk care managers. Sam stated that total spending into primary care did not go up a lot faster than the supply; the population was not growing more quickly than anticipated, that the new funding was going into clinicians, physicians, IT, and nurse care managers.

Cory mentioned that the report contained a chart that indicated where the primary care funding had been spent, and that it mostly was spent outside of the fee-for-service mechanism. Most of the money had gone into attention to care management and data infrastructure.

Teresa asked about the growing role of nurse practitioners and physicians assistants. Cory explained that it's a good question and that he would get back to the group on that.

Stakeholder Feedback:

- Improve the use of data to support OHIC positions and recommendations and evaluate progress.
- Develop ways to engage large employers.
- Consider consolidation of advisory groups and make meetings shorter.
- If infrastructure payments to PCMH are to continue, discuss greater enforcement of performance and when the payments will expire.
- Decide whether or not, and if so, how to support small practices.
- Use and/or develop better performance and/or outcome measures to measure care quality.
- Focus equally on quality and costs.
- Continue to move forward on primary care capitation.
- Engage ACOs more to leverage their expertise and gain their support.
- Engage specialists more.

- Take a more aggressive approach with hospital cost growth.
- Think about opportunities to engage the broader market, not just the commercially-insured. Medicaid and HealthSource RI are at the table, but not engaged participants.
- Place more focus on high-risk, high-cost patients.
- Dispense with episodes of care efforts - focus on total cost of care.

Teresa stated there are lots of regulations from DOH and that it's essential that DOH proactively participate, because from the hospitals point of view; they want to be involved in quality, but they also need to make sure that they're being consistent with the DOH. Cory shared that they have a primary care advisory group, in which OHIC brings matters to their attention and that OHIC does engage DOH in the Measure Alignment Workgroup; if there are specific issues that need to be addressed to please share those.

5. 2019 Affordability Standards Considerations

Clinician satisfaction with their work was not an item that was included in the evaluation but should become a part of OHIC's future considerations. The first six months of 2019 there will be a comprehensive review of the Affordability Standards based on the evaluation, and discussions will be held with the group and others. The plan is to look at the evaluation, revisit and revise the standards. As the advisory council it's important to get their thoughts and opinion and to provide feedback on how they'd like to be included in this work.

Does the group believe that the goals articulated around the Affordability Standards are the right ones? Are there areas that should be focused on or de-emphasized? Specifically, from a policy discussion. What is going on in the groups work and daily lives that we should be mindful of? How best can we utilize your time by helping us with these revisions?

Stephen stated that people are not seeing the impact or any relief, they do not see any rate improvements. Individuals and businesses alike are dropping insurance. It's important to think of the end user when writing these revisions. People have stopped him to discuss healthcare; they don't see the impact.

Teresa assumed that the report is going to enlighten some of the investments that were made in primary care. What were the goals that were hoped to be secured by primary care? If we are going to continue to have the Affordability Standards is it time for different goals? Especially if we have achieved the goals necessary for primary care. Alternatively, is there a desire to redirect that investment? If so, it's an important discussion. There is a lot of pressure for hospitals to make investments in population health; essentially, they've been investing in primary care. Are the goals that were established/enacted at the time the Affordability Standards still goals that should be secured? Is it time that those goals be reinvested towards the reduction of premiums on the commercial side? Or reinvested in population health? We should not assume the investment goal should be the same.

Cory stated that those are all questions being asked in the context of this review. The way we would access primary care work would be addressing where it has been successful, and if

additional tools through changes in the payment system might better improve changes to primary care? These are all questions we must answer.

Karl stated that it would be helpful to have a good frame of reference; it would be beneficial to have the current objectives and goals and an idea of the results so that the group would be in a better position to see what has and hasn't worked. Perhaps they could make some suggestions to redirect resources to address deficiencies and opportunities.

A matrix will be developed to review the goals and what's been done over the last ten years.

Ruth stated that she is uncertain what the limitations were of the Affordability Standards, but there was an emphasis on primary care. However, last year legislation was introduced to make the copayments the same in mental health as in primary care; the argument was that there was primary care in mental health, but it didn't look at behavioral health. Ruth stated this should be included in the next phase. Reimbursement rates also need to be addressed, because places are at risk of closing. If rates remain the same places are going to close, and the opioid crisis will get worse.

Dan's concerns were regarding primary care, specifically the supply of primary care physicians and other primary care providers. He addressed the average age of primary care providers and that many may be close to retirement. There is a struggle to recruit more primary care providers into the state. The supply of providers will be worse in a year. Dan stated that he's also concerned for small practices, which are being marginalized, and did not enjoy some of the funding that was available due to the economics of per capita funding, should they be supported? Or forced into larger systems?

Karl mentioned the presentation at the last meeting regarding waste and low-value products. If we could cut back on waste, we could invest in other aspects of the healthcare system.

Deb stated the hope around the ACO models had always been that there would be money that could be reinvested, not necessarily into the practice, but, for example, to buy an air conditioner for someone who has asthma, or to help with some of the social determinants. However, we aren't close to that point yet.

Teresa said Dr. Finale had mentioned at previous meetings that the actual cap for the ACO should be looked at; as its been unworkable, specifically concerning incentivizing. She stated that there was a member who submitted comments to the regulations regarding the cap. Cory briefly summarized what Prospect Health Services comments were and encouraged the group to go onto the Secretary of State's website for a more accurate representation of the comment and their requests.

Sam made two recommendations; access to in network health services, has been a long-term problem and should be addressed. Second, health insurance should be more about health, and there should be more transparency concerning population health.

Cory stated the discussion will be continued; and are to include legal reasons for the Affordability Standards.

Teresa requested that whenever possible the PowerPoint or larger reports be forwarded ahead of time for preparation.

Necessary and relevant materials will be forwarded to the group.

6. Public Comment

David was thankful for the email regarding the 2018 legislative changes and had a question regarding the reinsurance program, did it pass through the house? Commissioner Gamin stated yes, it passed at the very last moment.

David would like to know if there are any redlined documents that highlighted the changes to the Medicare supplement insurance minimum standards?

Sam explained that the document was re-codified, they reissued it under a new numbering system. Marie explained that she would confirm.

An anonymous person thanked the group for its focus on behavioral healthcare.

Ruth shared that The Mental Health Association of RI, had been working to prepare to launch the MH parity initiative on Dec 6th at Butler Hospital at 10:30 AM. Ruth invited the group. They've held focus groups around the state, training under RIPIN with Sam; and shared that it will be an ongoing initiative.

Meeting adjourned at 6:00 PM.

Next Meeting

The next meeting of the Health Insurance Advisory Council will be held Tuesday, December 18, 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.