State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
April 16, 2019, 4:30 P.M. to 6:00 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 Marie Ganim, Co-Chair Stephen Boyle, Teresa Paiva Weed, Deb O'Brien, Al Charbonneau, Shamus Durac, Vivian Weisman, Karl Brother, Hub Brennan, David Katseff, Laurie-Marie Pisciotta

Issuers
Liz McClaine, Neighborhood Health Plan of Rhode Island
Tinisha Richards, United Healthcare

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

Not in Attendance
David Feeney, Daniel Moynihan

Minutes

1. **Welcome, Introductions, and Review of March Meeting Minutes**
Stephen Boyle called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance. After introductions, minutes were accepted as submitted.

2. **RIREACH Consumer Update**
Shamus Durac gave a RIREACH consumer update. Throughout March, RIPIN saved consumers about $86,000. They have been continuing to track any of the surprise billing issues that were mentioned last month. It is too early to say that it is a trend, but we are a little worried because there has been a slight uptick in consumers calling with complaints about "junk" plans. Commissioner Ganim said that RIPIN should send over those complaints to OHIC. Steve Boyle commented that there was an article in the Globe about medical surprise billing – so the issue is starting to get some attention.

Commissioner Ganim commented that OHIC is working with RIPIN to report about behavioral health calls.

3. **ACO Description and Update**

Cory King gave an update about Accountable Care Organizations (ACOs) and a description about what they are. ACOS are all the rage in health care over the last few years. The phrase was coined by Dr. Elliott Fisher of the Dartmouth Institute. The concept was also instilled in the Affordable Care Act. The Medicare program was empowered to create a Medicare shared savings program which created a payment model to incentivize the development and operation of ACOs.

Medicare defines ACOs has groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high-quality care to their Medicare patients. The goal is to make sure patients get the right care at the right time. When an ACO succeeds in delivering high-quality care and reducing health care spending they can share in some of the savings that they generate.

ACOs may be classified into two types: Physician-based ACOs, and Hospital-based ACOs. In general, the ACO exists as a group of providers – it then contracts with different types of insurance companies. You can think the ACO as a multi-payer vehicle for system-transformation.

Why do ACOs exist? They exist to help us reduce health care spending and to increase quality care. The reducing spending part means they have to assume the accountability for the quality and the total cost of care of their attributed patients.

Karl commented that there are a lot of different ways to save money, one is to provide a higher quality of care, and another is to manage the amount of care you give. Karl asked if that is factored in – how do we know whether the quality is being improved or if a provider is providing less care?

Cory responded that ACOs are measured on the quality of the care they provide to patients and with large enough populations of attributed patients there is some degree of statistical certainty that any losses or savings are the result of real process changes as opposed to random variation. Cory continued, stating that some literature says that physician-based ACOs have been doing better than hospital-based ACOs.

Teresa commented that there are legitimate reasons for that because hospitals have to take people who are uninsured. Al commented that to be fair what the literature is saying is that hospital-based ACOs have had marginal success in terms of saving money from distinct populations.

David Katseff asked, who are these contracts with? Who are the ACOs contracting with? Cory responded that the ACOs are contracting with all of the payers – which are all of the insurance companies. They don’t necessarily have contracts with all of the insurance companies, but they do have many contracts. All of these contracts are all a little bit different and separately negotiated.

David asked if this has set up another bureaucracy/form of administration that takes times and costs money just to set-up the relationships between the ACOs and the insurance companies? Cory responded that there is expense related to these relationships but there is a lot of work that goes into not only developing the ACO infrastructure but also developing the contracts and executing and implementing them. Dr. Puerini commented that the crux of the issue is not only coordination but collaboration. That is why when we decided to team up with hospital systems we felt that that was going to be the only way that we were going to be able to help control specialty hospital costs. Because of the fact that we were able to coordinate care and make it seamless, the transition from hospital to PCP office and back, we were the only ACO in the region to save money while keeping the quality at 97%. To do an ACO as just a small group is much more difficult, whether you are a physician or a hospital – to us the reason we are successful is because we have a very good relationship with the hospital systems. A lot of the savings come from working directly with patients, hospitals, and PCPs – this work helps lower the readmission rates.

Commissioner Ganim commented that the contracts have built-in quality indicators, so it is not just the cost-savings. If it were just the cost-savings, there would actually be an incentive to deny access to care to keep the price down.

Vivian Weisman asked, considering how small the population is in Rhode Island, we only have a million potential. How small can a particular ACO be and not have the variance related to unusual medical incidents throw the whole system off? Corry responded that you definitely need contracts to have a critical mass to make statistical valid measurements – the Medicare program goes as low as 5,000 members – I don't think the commercial payers go as low. Roughly 50% of commercial costs are managed by ACOs, Medicaid may be higher.

Teresa commented that yesterday statistics came out yesterday, a survey went out to RI hospitals and RI is number one with the least number of readmissions and I think that goes directly to the efforts that we are seeing in this collaboration. Al commented that last week the Leonard Davis Institute from the University of Pennsylvania also came out with a state by state analysis of premiums over median-household income, and I think the numbers they quoted for RI were 26%. That means 26% of Rhode Islanders median household income is spent on health care – so, despite of the rate of readmission, we are not there yet.

Rhode Island has seven ACOs, Coastal Medical, Integra, Lifespan, Prospect Health Services, Providence Community Health Center, Blackstone Valley Community Health Center and Integrated Health Partners.

Commissioner Ganim commented that OHIC has one piece of legislation this year and it is to be able to ensure that these seven entities and any others that come along have the financial wherewithal to take on these contracts. It is not meant to be the heavy-hand to examine their quality, it is really to look at the financial solvency of these entities.

Steve Boyle asked are we seeing any reduction in the overall cost of health care? Cory responded that from a rate setting perspective, if savings are generated then those savings are reflected in the claims experience. Dr. Puerini responded that there is a reduction in growth but not an absolute reduction. Ultimately, that will overtime lead to a stabilization.

Teresa commented that OHIC is going to be reviewing the Affordability Standards in the context of ACOs -is there any more that can be shared about that? Cory commented that we had concerns several years ago that ACOs, who have a significant number of lives could potentially use that as leverage to negotiate higher than necessary trend factors. So we actually have a cap in place that after you apply risk-adjustment to the baseline, there is a cap on the inflation that is applied to get to the target PMPM – that is presently based on the consumer price index.

4. Reinsurance Update

Section 1332 of the ACA permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. In order for a state to get a waiver, we have to satisfy four guardrails: scope of coverage, affordability, comprehensiveness of coverage and deficit neutrality. Since the passage of legislation in the last session of the general assembly which authorized us to pursue a 1332 waiver around reinsurance and develop a reinsurance program, we have been working on all of this. This work has been led out of HSRI with OHIC as a partner.

Cory continued - Reinsurance – why did we choose it? We convened a Market Stability Workgroup and the goal there was to improve affordability and stabilize the markets. There are a lot of destabilizing things happening in health care right now. Fundamentally what we are trying to do is reduce premiums by taking some of the risk for high-cost claims off of the insurance company. Reinsurance has three relevant parameters: Attachment Point, Reinsurance Cap, and Coinsurance Rate. The Attachment Point is defined as the point at which the reinsurance kicks in, which is $40,000. Then, reinsurance is active up until $97,000, which is our cap. And then from there on the insurer is back on the hook.

David Katseff asked where we got the number $97,000? Cory responded that our actuaries had to review and do some projections of what the right amount was based on the budget we currently have for reinsurance. David asked if we have an idea of what percent of total claims, or what percent of total dollars from claims, would fit in that reinsurance category? Cory didn't have that specific number, but he responded that the premium savings are tied to the amount of risk we are taking off of the insurer – we are taking risk by covering a portion of the claims.

The coinsurance rate is a target, that is subject to change. If we have fewer claims than projected, or more revenue, than we might want to adjust that rate – it can change from year to year. Additionally, Article 14 of the Governor's budget proposes to create a state shared responsibility penalty which will fund the state's share of the reinsurance program.

Karl asked if Cory could explain what the shared responsibility penalty is, Cory responded that it is an individual mandate have health insurance. Teresa asked how much revenue the federal government collected last year? Cory said that during the most recent year the federal government collected over $8 million. The Commissioner responded that it was closer to $11 million. Steve Boyle said that the committee came up with this method because it was just really shifting money, since the mandate is something we have already done in previous years and we knew reinsurance probably could not have been funded from general revenue. Steve responded that the only difference from the federal mandate is that now when people are filling out taxes and have to pay the mandate penalty, it opens up an open-enrollment period for them through HSRI so they can avoid the penalty next year. Teresa commented that the reason she asked for this to be put on the agenda is because this is important, and the open-enrollment aspect is critical – and that we know this will not necessarily reduce premiums, but we know that it will slow the growth. Al commented that another aspect was the identification of the Medicaid eligible people, so there is going to be an effort to try and subsidize Medicaid eligible people – if they are eligible for Medicaid we are going to try and get them on Medicaid. Karl mentioned that he thought the pool would be $11 million, not $14 million – Cory answered that we are projecting that Rhode Island will make $9 million from the mandate and the federal government will contribute approx. $6 million into that pool. There will be some administrative costs in addition to the reinsurance program dollars available for insurers.

David asked if the reinsurance program will primarily benefit the individual market and sole prop – he thought it would be more beneficial to company sponsored insurance plans and large group plans who have not gotten the benefit of subsidies. The Commissioner responded that since the federal government now subsidizes only the individual market, that is the only place we can get federal money from – but if we put a state-only program in place we certainly could do it, but that would be quite a challenge. Cory said that the program is designed for the individual market and if we had a state program for the group market we would have to cover 100% of the costs for that, and I think the Market Stability Workgroup saw that the greatest vulnerability was in the individual market. Cory said that roughly 40% of the individual market is unsubsidized. David brought up that he wants to finds ways to help employees who get their insurance from their employers – they are not subsidized and this program will not help those people.

Cory explained that reinsurance is expected to decrease 2010 individual market premiums by an average of 5.9%. This doesn't mean insurers will reduce the rates, it means that it will deter growth. When we lower premiums, and lower tax credits, we will achieve that federal savings. Teresa commented that Steve and Marie have done a really good job of building consensus in the Market Stability Workgroup among the business group, consumers, and all of the insurers. David asked, the business community was part of the Market Stability group, and the recommendation to go to reinsurance doesn't help much of the population that the business community represents, I don't understand – why would the business community choose this? Steve Boyle commented that there was a lot of discussion – they quickly decided that not doing anything wasn't an option. They decided that there was only x amount of things we could do, and we had to choose something that

didn't impact the budget. The Commissioner commented that in the first month of her role here there was a public hearing on rate increases – and three of the people that showed up, a sole proprietor hair dresser, a sole proprietor attorney, and a sole proprietor accountant – they were the people being crushed by the lack of affordability of premiums. Steve commented that many employers should take advantage of the employer choice model through HSRI, that could be a big factor in stabilizing costs for these small businesses. Shawn Donahue commented that reinsurance is not something new, in the first few years of the ACA we had a similar program that worked well that expired – so have experience with that.

Public Comment:
Jamie Ingram commented on behalf of one of his members, they have concerns about insurance carriers who mandate 90-day prescriptions – it is problematic because we have concerns about overdose and he is wondering what could be done to address that. The Commissioner responded that the OHIC office reached out to the insurers that none of them are mandating the 90-day supplies. What we were informed of is that some self insured companies may be encouraging the 90-day supplies. We reached out to the health department and what they proposed is that the prescriber would actually limit it to 30-days. So it would be more by a case-to-case basis. Al asked, if the reason employers are recommending 90-days is because of the price? The Commissioner confirmed that employers recommend 90-days because it is more cost-effective.

Steve Boyle commented that he sits on the health services council, last week we approved a $25 million upgrade to Hasbro Hospital. It has been 25 years and it is pretty dated now. And today, we approved Westerly Hospital for a geriatric wing of the hospital for 18 beds. So there are good things going on.

Next Meeting:

- Tuesday, May 21, 2019 from 4:30 – 6:00 PM at the Thundermist West Warwick location, 186 Providence Street, West Warwick.