State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
November 19, 2013, 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 Hittner, Co-Chair Bill Martin, Michael Bailit, Al Kurose, Bill Schmiedeknecht, Hub Brennan, Linda Lulli, Howard Dulude, Karl Brother, Vivian Weisman, Rob Cagnetta, Pat Mattingly, Steve Boyle, Tim Melia

Issuers

State of Rhode Island Office of the Health Insurance Commissioner Staff

Herb Olson, Linda Johnson, Kim Paull, Maria Casale

Not in Attendance

Karen Fifer Ferry, Herb Gray, Peter Quattromani, Ed Quinlan, Wendy Mackie, David Mathias, Phil Papoojian

Minutes

1. Introduction and Welcome

Dr. Hittner and Mr. Martin collected the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance.

2. Review of Minutes

The minutes from the October 15, 2013 HIAC meeting were reviewed and approved with no changes.

3. Office Updates

Dr. Hittner shared: As we noted at our last meeting, we are in the process of hiring for 4 positions. Those positions are now approved, and will be posted November 25th for a three week period.

1) OHIC is still working hard on the implementation of the Affordable Care Act. Regarding President Obama's recent decision allowing states to let people continue to purchase policies, there has been a tremendous pressure on OHIC and the Exchange to decide how to handle this. The offices decided that we would make no changes in Rhode Island, because very few people who would be affected, and people have confidence in our exchange.

2) Last meeting, you asked about the changes UnitedHealthcare made in its networks for Medicare. This has been a big issue, with comments and questions within government. We do consider this a very important issue, because I believe these types of network changes are going to happen in the future. This can be a lesson on the "how" this gets done in the future. We have been working with RIREACH, referring patients there if they are losing their providers and they have problems finding another one. RIREACH has been helping place them with a physician. If there is a pattern, we will talk to United.

   Member of the council agreed that this was a big issue, and that how the carriers do this is very important. Dr. Hittner noted that especially within this situation (because OHIC does not regulate Medicare) she sees the OHIC role as one of a convenor, helping to figure out how to do this better in the future if necessary.

Kim: Evaluation of Affordability Standards

Kim began the discussion by describing the recommendations in Michael Bailit's presentations. She noted that first, she would then ask for any additional recommendations that Council members wanted to add from the full list that were not on the "for discussion" list.

Additions:

A council member proposed that the recommendations include transparency, with a rationale: more and better information, and more timely information about quality outcomes and cost. As a part of their decision-making process, consumers would then be better able to decide which physician network might better meet their needs.

Kim replied that OHIC had told Blue Cross Blue Shield of Rhode Island (BCBSRI) in its last rate review that you need to share price information. OHIC is now proposing to eliminate the requirement, and replace it with a transparency bulletin – creating a plan to share information at a service level, upon request.

Herb Olson noted that right now, it's by request from a provider. If a provider makes a referral, and wants to know what the price will be, the carrier needs to make that available. Each carrier is developing a much more comprehensive price transparency plan. Under the rate approval conditions, those plans are supposed to be filed this April. We are working with them, seeking updates.

The council agree that these two steps – one on request, and a more comprehensive plan coming this spring – were sufficient. It will be kept on the agenda.

Review of Michael Bailit's Recommendations:

Standard 1: Select Bailit Recommendations:
1. Update benchmarking study to determine whether the target needs adjusting
2. Continue to increase the percent of funding directed to non-FFS activities
3. Expand types of non-FFS spending to items that:

- *allow risk-bearing entities to better manage their patients (e.g., develop analytic*
- *capacity)*
- *promote behavioral health/primary care integration*
- *share support among small and independent practices to become medical homes*
- *promote evidence-based, community-based care initiatives*

4. Require insurers to reallocate unearned quality incentive funds to other primary care providers that did meet quality standards, targets or requirements.

Discussion: Kim Paull noted that as we do our benchmark study, we'll know where Rhode Island carriers stand in comparison to New England and the rest of the country. We might not need to increase it the target by 5%, but instead, we could increase it at the level indicated by the benchmark study. We are also proposing to expand what insurers can count as primary care spend – things that fundamentally improve primary care. For example, we might promote evidence based care, or going beyond a fee schedule and beyond what we currently allow.

After more discussion, the council agreed that they wanted to accept the recommendations as Michael Bailit originally proposed them. (The council specifically did not accept OHIC's proposed changes to Number 4.) The Council will continue to discuss exactly how to carry them out (especially Number 4,), once the benchmark study is done.

#2 – PCMH's –

Michael Bailit presented four mutually exclusive ways to invest in best practices in Primary Care Medical Homes:

Bailit Recommendations (mutually exclusive):
(1) Retain current program structure and quickly expand both CSI and proprietary PCMHs
(2) Transform CSI into a parameter-setting entity with aggressive expansion targets
(3) End proprietary PCMH and require insurers to expand CSI
(4) End CSI and require insurers to quickly expand their specific medical home programs.

Kim Paull noted that OHIC's proposal was to accept Number 1 and develop an operational definition for "quickly expand," because there are many primary care practices that are not expanding.

Vivian – strongly agree. To take either the PCP's who have just gone through a transformation and give that up, then people would have to unlearn and redo.

After additional discussion, the Council agreed with OHIC's recommendation for Number 1.

#3 – CurrentCare.

Michael Bailit presented his recommendations on CurrentCare:

Bailit Recommendations:
1. Retain as is and continually monitor to determine whether HIE benefit has been realized
2. Based on future assessment, consider whether Currentcare should qualify as Primary Care Spend
3. Currently, limit percentage of non-FFS spending that may be directed to CurrentCare to avoid diminishment of direct PCP support.

OHIC laid out the following additional proposals for the Council to choose between:

A. Proposal:

- *To increase Currentcare enrollment and use at point of service, require payers to*

develop programs that either:

(1) Design a strategy to educate providers and encourage patient (?) sign-up at the appointment. Include work flow integration and training on how to best "use" Currentcare.

OR

(2) Design a strategy to educate providers and encourage patient (?) sign-up at the appointment. Include work flow integration and training on how to best "use" Currentcare

AND

Encourage Currentcare sign-up at the time of enrollment with a standard form and sign-up process established among issuers.

- *Allow payers to use primary care spending to achieve the above objectives. Data and reporting would be required to validate such expenses.*
- *Explore the use of community resource organizations and state agencies such as HSRI and RIPIN/RIREACH, CVS Minute Clinics, Medicaid, Dept. of Elderly Affairs to explain process and enroll consumers*
- *Re-visit the ease and efficiency of the sign-up process to determine if adjustments are needed to program protocols*

After discussion that included affirmation of the value of CurrentCare, the Council agreed with the three Bailit recommendations in the beginning of this standard. And, OHIC, on its own, would look at A2 and the three bullets that followed – but not as a part of the Affordability Standards. The office would look at using its resources to help design or talk through a strategy to enroll, because it has been asked to do so.

Standard 4 – Payment Reforms

Bailit Recommendations:
(1) Require insurers to contract with providers on a population basis for a specified percentage of covered lives *(increasing each year)*
(2) Require insurers to include downside risk in population-based contracts for a specified percentage of covered lives *(increasing each year)*
(3) For population-based contracts, replace the annual, price-based revenue limit with a comparable, population-based revenue limit.
(4) Establish governance standards for risk-bearing providers that promote primary care, and care coordination from a medical home.
(5) Require payments to include a quality component
(6) Collect outcome measures to determine if desired results for the Hospital Contracting/Payment Reform Standard are being realized.

Kim opened the discussion of this Standard by noting that OHIC was proposing that the Council approve Numbers 1 and 2.

After discussion about the data that was important to collect and measure, and how the state should work with providers who would accept downside risk, the Council agreed with Numbers 1 and 2, and wanted more time to discuss the other standards. In particular, Numbers 4 and 5 were deferred to the following meeting.