State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
May 21, 2019, 4:30 P.M. to 6:00 P.M.
Thundermist, West Warwick Location
186 Providence Street
West Warwick, RI 02893

Attendance

Members

Co-Chair Commissioner Marie Ganim, Co-Chair Stephen Boyle, Teresa Paiva Weed, Shamus Durac, Karl Brother, David Feeney, David Katseff, Laurie-Marie Pisciotta

Issuers

Liz McClaine, Neighborhood Health Plan of Rhode Island
Tinisha Richards, United Healthcare
Shawn Donahue, Blue Cross Blue Shield of Rhode Island

State of Rhode Island Office of the Health Insurance Commissioner Staff

Cory King

Not in Attendance

Daniel Moynihan, Hub Brennan, Al Charbonneau, Vivian Weisman, Deb O'Brien

Minutes

1. **Welcome, Introductions, and Review of April Meeting Minutes**

   Stephen Boyle called the meeting to order, welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance, and asked for a motion to accept the April minutes. Karl Brother pointed out that on page five a date reads '2010' instead of '2020' – with that correction, the minutes were accepted.

2. **RIREACH Consumer Update**

   Shamus Durac gave a RIREACH consumer update. So far in 2019, RIPIN has $330,000 in total savings. RIPIN had a case last month where a person had a fully insured plan from their work in Rhode Island. They needed emergency ambulance transportation from a friend's house nearby in Massachusetts to Rhode Island Hospital. Because it was a Massachusetts ambulance there were difficulties filing the claims. It took almost 5 months to get this resolved but finally was resolved and the consumer liability was reduced to $1,800. As far as trends, RIPIN has been doing a lot of work with the parity

initiative, including giving some training to the community. With our work with EOHHS, OHIC, and other self-insured plans we see parity as an important issue across the board.

Steve Boyle asked Shamus to explain what RIPIN does just in case anyone who came from the public doesn't know. Shamus explained Rhode Island Parent Information Network (RIPIN) is a nonprofit formed in 1991 by a group of parents of children with special educational needs, and it has evolved over the years to be an organization that works both with educational needs and health care. They now run a call center that supports any Rhode Islander that has an insurance issue, whether with Medicaid, Medicare, fully insured commercial plans, etc. In 2018 RIPIN saved consumers $2.25 million. Karen Malcom from Protect Our Health commented that having RIREACH as a resource for the community has been a critical resource for consumers and MARI's parity initiative has included RIREACH's phone number on their new flyers.

3. **RI Executive Office of Health and Human Services (EOHHS) Integrated Data Ecosystem—Overview and Discussion**

Kim Paul, the director of analytics for the Executive Office of Health and Human Services (EOHHS) gave a presentation about the Integrated Data Ecosystem. The EOHHS data ecosystem is a place where the state has put data together to help understand the people that served in a more holistic and integrated way. "Why" data ecosystem? There is a real impulse within EOHHS to think beyond the person who we are seeing today – What family structure do they live in? What other services do they utilize? What are their other needs? Unfortunately, data doesn't always allow that. There is a real recognition that when somebody comes to one of our agencies to receive a service or a program, they are generally receiving services from other agencies as well. Knowing that, there was a sense that we were not getting the bigger picture on these people unless we put the data together. These are whole human beings. So EOHHS created a user-friendly analytic experience for the data-pros who really guide the entire strategy and structure of our programs. This process would pull data together from all EOHHS agencies and create a nice visual interface for people who have permission to access this de-identified data. Because some of this information if very sensitive, it is securely stored, and a limited amount of people have access to the identifiable information.

Karl Brother asked, what does this have to do with UHIP? Kim responded that UHIP data is included as one input source.

The Ecosystem started about 18 months ago and has collected 1.3 million individuals– it is larger than the state of Rhode Island because data goes back into the 1990's. Fifteen or more data sources and over one hundred users in the state have access to pieces of the data. We have had major cross-agency projects, one of our biggest being a child-maltreatment project. Because of the insights, many of our agencies are reorienting how they engage with families who may be at-risk of having a child maltreatment case in their home.

David Katseff asked if Ecosystem is more parallel to APCD, because the slide says, "data sources *with* APCD."

Kim responded that APCD is there for reference point, it is sitting on the same box, organized by the same people, but it is not part of the connected data. The systems are used for different purposes, sometimes shared purposes – they use the same structure and hardware, but they are not actually connected. There are limitations governing the APCD in state law.

Steve commented, asking what is the Boston Fed Reserve project? Kim answered that the Boston Federal Reserve has a community policy research arm interested in knowing the effect of medical assisted treatment on wage recovery. So we are working with them to help them understand when somebody has an opioid abuse disorder what do their wages look like?

Kim continued, one of the real big value adds that we provide is that we take messy data that is hard to make sense of – and we help people make sense of it. It is taking 300 Medicaid tables and putting them together into one table that is easy to view and understand.

Our big project last year has changed the way the state engages in families across agencies. We put our data together to try to understand children who have an indicated abuse/neglect case before the age of seven. We saw a couple things – one was that from a community perspective the place where a child lives matters incredibly. Location was the number one most indicative factor of child abuse. We also learned from a family perspective, families who have parents with substance abuse or severe mental illness have a higher likelihood of having a child in their home have an indicated abuse event. This data helps us better serve families and parents – now, when adults come to us, we will ask them questions about children at home. Finally, we learned that children who are not receiving regular care are also at-risk for childhood abuse/neglect. Something important that the data showed us is that when thinking of the children, it is important to think about the parents – most of the factors that led to higher risk of abuse/neglect involved factors involving the parents, not the children.

Kim pointed out that a parent with an opioid abuse disorder is 6.8 times more likely to have a child with an indicated abuse event, than a parent who does not have an abuse disorder. But, a parent with MAT is only 2.8 times more likely to have a child with an indicated abuse/neglect event. So, it is not perfect, but MAT is an important factor here. Every one of our agencies plays a role to prevent child abuse and neglect. We don't have to be a reactive system, we can be a preventive system.

There is a real value in strongly considering MAT for those willing to accept it – we saw emergency visits drop, wages recover, spending go down – so there are a lot of benefits here.

Karl Brother commented, have there been treatment plan changes, policy changes, because of this information?

Kim responded, we got higher enrollments in the MAT training after these slides were delivered. The power of these treatments was so clear after they saw this data. We are learning how we can do a better job training physicians and clinicians about assisted treatment methods.

The next slides detailed data of avoidable ED visits for Medicaid patients – which visits were emergencies, and which could have been a visit at a primary care doctor instead. This data can help us figure out if PCPs should have better hours, if their phone numbers are not available, etc.

Teresa Paiva Weed asked if the data considers the aging population? Kim responded that no, not yet. A related question was brought up about seniors – is the data capable to have an elder abuse study? Currently, Kim responded, that is something they want to have in the future. They are trying to figure out if there is something that exists similarly – connecting that person to a family member is quite challenging – we need to figure out the path to finding that data. It is more challenging than the child abuse study, but it is something they want to achieve.

4. Health Care Affordability Benchmarks – Overview of OHIC's Efforts to Make Health Care

The agenda item was initiated by David to get a sense of what metrics we can look at to judge whether insurance or health care in general is affordable to middle class Rhode Islanders. Cory King presented, affordability is a rather intuitive concept, and it is also a relative one.

Why measure affordability? There are a lot of reasons. If you are below the federal poverty level, you probably cannot afford health insurance – so, the state and federal government will provide you with insurance. If you are a purchaser of insurance on the individual market and do not have the benefit of an employer who pays for most of your insurance, the federal government will offer you subsidies – these subsidies all depend on affordability calculations. In terms of policy, it is important to evaluate whether the regulatory policies we have in place are having an impact on affordability. Lastly, it is important to measure affordability so that we can get a sense of the burden being placed on families, businesses and taxpayers.

A Leonard Davis Institute of Health Economics study from the University of Pennsylvania calculated average family premium as a percentage of the median household income in the nation and in each state. Rhode Island is in the middle of the pack – in 2016 the average family premium for employee sponsored insurance represented 29.2% of the median family income in Rhode Island.

Commissioner Ganim asked if the 29% is before the employer contribution? Cory responded that that is total premium – what it doesn't include are the out-of-pocket costs. So it is a good measure, but it is not perfect. These individuals could be having a $2,000 deductible. It is difficult to capture in one single metric the essence of affordability.

Steve Boyle asked, is there any break-out on the data of the premium against the individual market, not being subsidized – what that impact is on their relative income? Cory responded that this report looked at employee-sponsored insurance, so it did not capture the individual market. For the

individual market, you could look at the unsubsidized population and calculate what percentage of their income they are paying in health insurance. A lot of the individual market is subsidized to some extent.

One of the questions we get is: What is OHIC doing about affordability? Well, we have something called the Affordability Standards which is a set of regulatory requirements on commercial payers where we essential prescribe methods/initiatives for them to improve the affordability of their products and to improve the quality of health care. One requirement which has been impactful is a cap on the allowable hospital contractual growth from year to year. The Affordability Standards attempt to get at the underlying causes of medical trend which can create a very unaffordable situation. We also have a process called annual rate review. When we meet again, we can talk about the 2020 rates in more detail. Rate review has managed to reduce premiums, which creates savings for consumers. In 2017 when we reviewed rates, we cut about $16 million off of the original rates as filed. The other piece is that we have adopted a cost-growth target, working collaboratively with EOHHS. Some of the most important and large players in the market have volunteered to work to keep costs at or below 3.2%.

Teresa Paiva Weed commented that the cost growth target is something very different from the Affordability Standards. This is a very sensitive subject for those that voluntarily signed on to the cost-growth target. Her question is, what do you see as the relationship between the affordability Standards and the cost-growth target?

Cory responded that he didn't mean to convey a relation between them – these are distinct buckets of initiatives. The cost-growth target is a more global initiative while the affordability standards are more focused, and rate review is even more focused. How do they relate? So, the cost-growth target is focusing on total cost of care across all public and private insurers, looking at its growth over time. The Affordability Standards are really focused on a few sub-components of the total cost of care and limited to commercial insurance.

David Katseff mentioned that the arrows should be rearranged – the premium rate review and the Affordability Standards feed to the objective of the cost-growth target, so what hasn't been said before – is, what are we trying to get to? The overall costs going up by 3.2% is a goal and not a cap on premiums.

Karl Brother said, the mortgage industry has a standard that you should not be spending more than 30% for your housing costs. There should be some measurable number that is identifiably and reportable so that we can measure – and it is not just the premium, it is the total out-of-pocket consumer cost. Cory responded that the insurers can show a distribution of subscribers who had out-of-pocket costs in which range, including who hit their deductible etc.

Teresa Paiva Weed commented that these things are either by a consumer's choice, or an employer's choice – so when someone selects a health care plan for their employees, the employer

makes the decision what the cost-share, what the deductible, what their co-pays are going to be. Similarly, if an individual goes on the exchange, they make the choice. So, what is the value of that information?

Steve Boyle responded that he thinks the point is what we can say is affordability, and how does that impact an individual's budget?

Commissioner Ganim responded that as part of the cost trend, as part of that target goal, there will be a report generated every year on costs and the intent is to include measure of how much out-of-pocket costs increase.

Teresa Paiva Weed commented that she was hopeful the meeting would be more focused on Affordability Standards – and asked what the timeline is for comments on the advance notice and the public meeting?

She stated that the group that is the most impacted by this is the hospitals, this is the significant issue to impact the hospitals since 2010, most of the hospitals will be providing written comment individually. She wanted to make sure the hospitals have a chance to give their input.

Public Comment:

Mary Scialabba addressed the council about her concerns and challenges with the insurance industry. Her testimony is regarding her personal experience, but she knows that the challenges she has faced must impact many consumers in Rhode Island. She used to have the best of the best insurance, and after a car accident, her insurance has felt like the worst. Prior to going on this new insurance, she felt she received quality care from her doctors – now she feels the care is extremely low-quality. She doesn't feel anyone cares about her health anymore. She feels the doctors are hesitant to run tests, refer her to specialists, and prescribe medication. What she wants the insurance companies to understand is that when a patient finally gets an appointment, the patient has already been in pain for at least 30 days. Then, if a test is needed – it could take an additional 30 days. And with insurance denials, appeals, etc., the patient can end up waiting over half a year to have their pain treated. Can you imagine trying to function for 6 months through pain because the insurance companies do not approve the tests? Because of these denials, the patients end up having more problems arise because they waited so long to get treated. Insurance companies end up needing to pay more money for more surgeries/visits because they denied the original tests. Insurance companies make consumers feel like they do not care about them. She concluded by saying that this service is unacceptable.

Next Meeting:

- Tuesday, July 16, 2019 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.