State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
February 20, 2024, 4:30 P.M. – 5:30 P.M.
1511 Pontiac Avenue
Building 73-1
Cranston, RI, 02920-4407

Attendance:
Members:
Co-Chair Acting Commissioner Cory King, Al Charbonneau, Hub Brennan, Shamus Durac, David Feeney, Eugenio Fernandez, Bob Hughes, Laurie-Marie Pisciotta, Lisa Tomasso (on behalf of Teresa Paiva Weed)

State of Rhode Island Office of the Health Insurance Commissioner Staff
Taylor Travers

Not in Attendance
Catherine Cummings, Jocelyn Foye, Mark Jacobs, Daniel Moynihan, Sandra Victorino, Lawrence Wilson

Meeting Minutes

1. **Introductions and Review of January Meeting Minutes**
Cory King, Acting Health Insurance Commissioner called the meeting to order at 4:30 PM. All members voted to approve the January meeting minutes.

2. **Rhode Island Parent Information Network (RIPIN) RIREACH Update**
Shamus Durac of RIPIN provided an update for HIAC members. Medicaid redeterminations continue for families with children. RIPIN recently did a webinar with EOHHS, DHS and HealthSource RI to provide additional information about the process, specifically for families with children. The volume of redeterminations has increased significantly with January renewal dates more than double what they had been prior. State databases show how much of an impact the redeterminations have, focusing on if the redeterminations are taking longer, and denial rates increasing or decreasing. The state projected families with children renewing would be done passively. This appears to have changed as passive renewal rates have decreased significantly. There concerns are tempered with a lack of information as of current. He noted that during open enrollment, many individuals enrolled in plans that were thought to be exchange plans. However, they were actually enrolled in a limited benefits policy, which does not cover many substantial services. Shamus was asked if there was a requirement for public reporting of this data. Prior to December, Rhode Island had agreed that they would publish the families with children's data separately from the

adults only data. Shamus advised that the database is typically updated in the middle of the month. As of the January reporting, the data was split by non-children's enrollees and children's enrollees. There is a small number of people with non-compliant ACO plans, which is seen more in self-insured plans. He added that google search engine results used to filter the results and display the Rhode Island HealthSource website at the top, noting that this is no longer the case. This has been flagged and entities with jurisdiction over this are aware, although it is a slow-moving process.

Al Charbonneau noted that the large group and small group markets have decreased significantly in years past, almost 40-45% as an average. He wonders how much of this decrease could be due in part to these other online options.

Shamus advised that looking at the percentages of individuals enrolled in different plans, it appears to be a small number of individuals that are enrolled in these non-traditional plans.

3. Affordability Update

Acting Commissioner Cory King provided an affordability update, consisting of two items. At the previous meeting he provided an overview of the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Which is a federal Medicare payment initiative through partnerships with states. Rhode Island has submitted a non-binding letter of intent to apply for cohort three, with the official application due in August 2024. Rhode Island had additional time to submit this letter of intent but has decided to submit. However, the state has not made the final decision to apply for the AHEAD model as EOHHS is still evaluating all current initiatives. There is a need to have further discussions with hospitals and primary care providers. He noted that last week, CMMI posted the financial specifications for the Medicare Global Budget, which does need to be reviewed by the hospitals. CMMI also published a document detailing how different types of payment initiatives through Medicare can overlap or not. Cory is still reviewing that document, but he does not believe it goes into the level of detail needed to fully understand how existing shared savings opportunities that ACO's will garner can be impacted by the creation of the hospital budget. This is a technical issue that needs to be understood fully prior to submitting the official application. Cory added that there is a rumor that four states have submitted letter of intents thus far, which leaves four more slots if all that have applied thus far are selected. EOHHS will finish their evaluation to determine the AHEAD model feasibility for the state. Cory added that there have been preliminary discussions with hospital CFO's, which have been productive. There have also been one-on-one discussions with hospital leadership and EOHHS. Cory added that they had been planning on CMMI to publish the financial specifications, so that hospitals could evaluate those. Cory has heard positive feedback from primary care providers and provider groups who look at the opportunity to secure revenues from Medicare, which is a component of this model. He noted that it is not just a hospital global budget but also an increased investment in primary care through the mechanism of Medicare Fee-For-Service. CMMI has been clear that the

use of regulatory levers is something that the state should consider. He added that the state needs at least one commercial payer and one hospital on board.

The second affordability update focused on the cost trends work. The Cost Trends Steering Committee meets quarterly. He acknowledged that there has been expressed concern that quarterly meetings might somewhat impede momentum. Currently, they are completing the cost trends analysis. This analysis reviews total health care expenditures for the state as a whole and total medical expenditure for each market, Commercial, Medicare and Medicaid. The Steering Committee also reviews total medical expenditures for health insurance companies and large provider organizations. The data was sent to providers in January for data authentication, there have not been many responses as of yet. The annual report is set to be released in early May; notice will be given of a public forum which will take place on May 13th. This forum will review the states performance against the cost growth target, He is hopeful for positive news. They will also be unveiling some new items as part of the analytics. He added that they recently integrated 2022 claims data within the OHIC data hub. Lastly, they finalized the selection of public health and health equity improvement measures, the baseline performance of those measures will be part of the annual report.

4. January Data Story

Cory outlined the January data Story which focused on the increasing costs of prescriptions drugs. OHIC identified their analysis of claims data that the cost per member per month is rising, not because the number of prescriptions is increasing but the payment per unit of the individual drug is increasing. The primary driver is brand name drugs, which is growing at a higher rate than generic drugs. This data story focuses specifically on brand name drugs, and OHIC does have public facing dashboards and internal analytics available for review within the data hub. Cory indicated that the two highest spend drugs within the highest spend categories are Humira and Stelara. He maintained that much of health policy is about tradeoffs, as health insurance premiums increase, wages are not able to grow at the same pace. More of families take home pay is spent towards an increasing deductible. The cost of one year's supply of Stelara is approximately equal to 1,119 primary care visits per OHIC's analysis. The more you spend on brand name drugs the less you have to spend on primary care.

Lisa Tomasso communicated that although drug manufacturers are not transparent about rebates offered for particular products, the insurers take money in as some sort of revenue to offset costs. She asked if the insurers report to OHIC about this information.

Cory explained that as part of their annual total medical expense reporting, OHIC receives aggregated data from insurers. The net of rebate prices is still growing at a high rate, OHIC has asked where the rebates go. In past rate reviews, they have asked do they benefit the end consumer. They have received some information in regard, but it is still a bit opaque.

5. Administrative Simplification Taskforce Update

Taylor Travers outlined the slide deck handout provided to all members and attendees. Slide two provided an overview of the problem statement, which was defined as "Prior authorization is a form of utilization management that has an important role to play in the provision of medically necessary care under health benefit plans. However, health care providers and those speaking from the patient perspective, have articulated reasonable concerns with the application of prior authorization and the resulting burdens placed on those involved in the provision of patient care." Slide two also outlined the provider view which included the following bullet points categorizing prior authorization as increased administrative burden, increased operating costs, potential jeopardizing of patient safety, and a contributor to clinician burnout. The patients' view was defined as: "Experience of care can be materially and adversely impacted when the application of prior authorization creates real, or perceived, barriers and delays in accessing care." The payor view consisted of the following bullet points: [prior authorization] is a utilization management tool promoting evidence-based care, [prior authorization] reduces wasteful spending, and [prior authorization] promotes patient safety and affordability for health care purchasers.

Slide three contained the recommendations for actions introduced in the CTC-RI report. #1 Reduce the prior authorization volume, #2 Improve the prior authorization data collection, #3 Create an ongoing statewide advisory committee, #4 Evaluate therapeutic substitutions at the pharmacy, #5 Implement technologies that improve the process, and #6 Identify and reduce processes that are 'PA-like.'

Slide four outlined the straw model proposal, which consisted of Part A and Part B. Part A proposed the elimination of the prior authorization requirement from all medical services meeting the following criteria: an average threshold approval of 95% + or higher and an average cost of $25,000 or less. Part B proposed the elimination of prior authorization requirements for all in-network behavioral health services.

Cory provided additional information regarding the straw model proposal which consisted of the creation of guardrails around the application of prior authorization. Some complaints include time spent on the phone with the insurer which cannot be controlled. However, what can be controlled is the number of times that require the phone to be picked up. He indicated that the question then is how you would set the parameters for reducing the services on the list. It cannot be such an expensive of a service that maybe prior authorization should be applied from a cost perspective. The review has to include the volume of requests, approval rates, and cost. He further explained that the implemented tool has to be simple and provide direction.

Slide five presented the prior authorization data including service categories and volume of requests received by three insurance carriers (see attached slide deck).

Slide six contained data grouped again by service categories, with volume of requests in addition to the approval rates for each of the service categories (see attached slide deck).

Slide seven outlined the top ten reported service codes with the highest request volume and the corresponding approval rates (see attached slide deck).

Slide eight outlined the provider perspective, provided to OHIC. What was heard was:

- Can payers streamline authorization requirements and processes across all products under one payer.
- Ability to consider 'like' procedures. CPT is submitted and approved, procedure changes at time of service and is denied. Medical Necessity appeals rarely overturn in these cases.
- Develop clear avenue for communications on changes and requirements, some communications are not received, late, or vague.
- Ability for retrospective reviews and medical necessity overrides for administrative failures.
- Authorization requirements change midstream during active treatment cycles causing denials and potential disruptions in treatment.
- Repetitive requirements in cases where treatment plan (formulary needs) change.
- All payers do not support electronic submission of prior authorization.
- Processes vary from product to product under one payer.

Slide nine outlined the payor perspective, what was heard from conversations included:

- Services currently requiring prior authorization are reviewed on a quarterly basis by a workgroup. Services are evaluated for potential removal from the PA list based on factors such as product (Commercial plan VS Medicare Advantage), approval rates, appeals overturn rates, regulatory mandates, market trends, provider burden, and impact to members.
- Notifications of policy reviews are issued through monthly Provider Update articles.
- Insurer utilizes a medical management platform/provider portal, MHK, that includes the internal capabilities to review and make decisions on prior authorization requests, as well as an external-facing provider portal to submit and monitor requests. This integrated application portal allows providers to submit authorization requests to see a real-time view of their case and approval status. Providers can upload attachments and notes.
- The insurer helps members with continuing needs find alternative sources of care when members' benefits change or end, or when providers terminate from the plan. Processes are in place to ensure continued member access to necessary medical care and services to prevent disruption or delays in treatment during periods of transition of changes in member benefits.
- Continuity of care is taken into consideration in criteria for most drugs. The plan allows a 30-day supply for certain drugs if a member is currently on therapy and the review is pending appeal.

Cory highlighted that when the services are reviewed, the distribution of volume may differ based on the specialty or provider. Piggybacking on OHIC's Primary Care Report issued in December, Cory wants to focus on the impact on primary care providers. The goal is to address the primary care burden, alleviate that burden, as they are the most vocal. He noted that additional analysis is necessary. He concluded that the final report with recommendations is due to the General Assembly by June 30, 2024.

Laurie Marie Pisciotta asked if there are any plans to engage consumers in the conversation. Particularly their perspective when they are subject to step therapy.

Cory indicated that during the course of the task force meetings, some people spoke up as consumers. There have not been specific initiatives to gain patient feedback.

Laure Marie expressed that if there are plans to have any focus groups, she is willing to assist in promoting those meetings.

Eugenio asked about the consumer and the pharmacy perspective. As the pharmacists are the ones that have to tell the consumers that a drug may not be covered.

Cory mentioned that there will likely be a subsequent task force dedicated to the pharmacy issue. If the straw model proposal is applied, as regulation, as there probably will not be consensus from the task force, there can be application to the pharmacy space. He further indicated that there was a bill introduced at the general assembly to focus on prescription drugs.

Eugenio inquired that while reviewing the provider perspective, he wonders what the pushback is from payors on item #1 'can payers streamline authorization requirements and processes across all products under one payer.' He notes that this seems like a pretty reasonable request.

Cory explained that the issue may be with regulatory requirements. He also indicated that it may be one payer specifically, and there potentially may already be plans to streamline. He invited members of the audience to comment on this.

Dr. Peter Hollmann, a member of the audience from Brown Medicine, outlined that it may be due to Commercial, Medicaid and Medicare specific requirements that are different for each. He also added that because of the self-insured products there are different formularies. As an example, he noted that for one of the companies it isn't hard to look up the formularies. For another company they may have 40 different formularies, which requires the input of the specific member ID. They utilize CoverMyMeds.com which is a helpful resource. There is a wide variety of reasons for these different things, some of which can be considered excusable and understandable.

Al explained that his worry with the task force is if something is changed, then we don't look back. There is a necessity to review and look at the impact of it, evaluating and reporting out, if it is making the scenario better or worse. He thinks this a function primarily of a Fee-For-Service system, that promotes this need to clamp down on things. If there was a more standardized evidence-based approach there would be less need for these types of things. His feeling is that if the system doesn't work from a procedural point of view, it needs to be fixed. On the other hand, he believes there are good reason why the rules were put in place in

terms of utilization. He has heard that specialists are clogged with patients that don't necessarily need to be there. There is an impact financial, and emotionally of receiving services that may not be needed. Concreting that there is a basis to it, but the process does need to be fixed. He would like to see some sort of evaluation of this, so that patients get what they need. He believes that providers may err on the side of doing too much as opposed to the right amount.

Lisa asked if a comparison has been done with the received data to other states. As an example, she noted the Rhode Island ranks relatively high in emergency room visits. It is not the fault of consumers or the emergency room, but it signifies a problem of providing healthcare in the community. From the perspective of the prior authorization data, is that also symptomatic of something wrong within the landscape. She added that radiology is the highest volume service category but is that proportionate to other states. Imaging is also associated with defensive medicine; she wonders if there is something that can be gleamed from a comparison to determine the root issue.

Cory added that if there were claims data across different markets there could probably be some different benchmarks of the service utilization/

Al added the regulator should be able to ask this in order to better understand what is happening within the system.

Bob Hughes in response to Al's comment, wonders if there is previous research on prior authorization that can inform.

Cory noted that a literature review has not been done. He added that United Healthcare recently did an assessment of services subject to prior authorization, looking at a cost benefit analysis of it. Although they did not share the methodology behind it. He added that insurers use prior authorization to manage cost, if the tool is taken away how then do they manage cost.

Shamus added that it is important to conceptualize this through the patient perception of care, not just the patient experience. He added that it is not just whether or not the service was received, it is more so how the relationship was affected, both with the provider and the carrier. Limiting the proposal to low unit cost and high approval rate, but also looking at areas where the value proposition is. There was a significant throttling of access to primary care. He thinks it is important that the straw model identifies that as a specific jumping off point. He added that the throttling is where the patient experience of care is, which is seen as problematic. In a full risk model, where the need for prior authorization is eliminated at the payer level there are still concerns that need to be internalized in the way it is looked from the patient perceptive. Where that throttling of care could be more pernicious because it is not subject to that same level of oversight as a formal request which is then turned into a

formal denial. At the service level the service is just not ordered because of the internalized thought process around the risk and cost to the system within the patient's specific visit.

Al added that with respect to hospital global budgeting, and specifically the example that comes from the Maryland experience. If there is a problem with inappropriate utilization of the emergency department, right now you have to bring the patient to the hospital to get the revenue. In a properly constructed hospital global budget, you can take that revenue and move it into an area where the patients need service and can be served at a lower cost.

6. Public Comment

Rich Glucksman of Blue Cross Blue Shield Rhode Island thanked OHIC for the work on digestible data stories. In regard to prior authorization, they have submitted the requested data, as they are fully committed to engage in the discussions. He added that affordability is a huge issue, as well as health and safety considerations that go into those prior authorization decisions. On the patient side they hear the concerns with access to care, and the feeling they have when they are denied for services. There is a consideration there that some services may not be medically necessary that a patient is then asked to pay for. There is also a patient payment perspective, especially with higher deductible health plans. There are a lot of considerations out there. He appreciates Shamus' comment highlight that how this moves with payment mechanisms, it triggers a different regulatory framework that might be considered. For payers, a patient currently has a right to appeal internally as well as externally, he wonders how this would then fit in.

7. Notice

Cory announced to members and attendees that Steve Boyle has resigned as Co-Chair, after a decade of service, taking a well-deserved reprieve from OHIC related matters. He communicated that the HIAC then needs another Co-Chair.

Cory touched on the cadence of the HIAC meetings, adding that when the HIAC was convened in 2005-2006 it was the only public body that OHIC convened, and there are now several. He will be thinking independently about the meeting cadence and if it makes sense to meet every other month. He will also be thinking independently about a new Co-Chair.

Laurie Marie asked that in addition to the meeting cadence, is there a way to amend the public body act, to allow for virtual meetings.

Cory highlighted that he would love to amend the open meetings act to allow for virtual participation at all public bodies, but unfortunately it has not happened yet.

The meeting was adjourned at 5:30 PM.