State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
January 16, 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, Daniel Moynihan, Mark Jacobs, Sandra Victorino, Shamus Durac, Bob Hughes, Lisa Tomasso (On behalf of Teresa Paiva Weed)

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

Not in Attendance
Co-Chair Steven Boyle, Catherine Cummings, David Feeney, Jocelyn Foye, Teresa Paiva Weed, Laurie-Marie Pisciotta, Eugenio Fernandez, Lawrence Wilson

Meeting Minutes

1. **Introductions and Review of November Meeting Minutes**
   Bob Hughes was introduced as a new member of the Health Insurance Advisory Council. Meeting minutes were not voted on as quorum was not reached at the December meeting. All present members introduced themselves.

   Al Charbonneau asked if an affordability update could be added as an ongoing item on the HIAC agenda, as it used to appear in the past. Cory King noted that the affordability item would be placed on the agenda for all future meetings.

2. **Rhode Island Parent Information Network (RIPIN) RIREACH Update**
   Shamus Durac shared that the office has been continuing to see cases surrounding the resumption of Medicaid renewals as of April 2023. They continue to assist consumers navigate the process, field questions regarding the application process, and assist in the transitioning from Medicaid coverage to insurance from Healthsource RI. Households with children resumed this month. Departments EOHHS, DHS and HSRI scheduled meeting for best practices on Friday, January 19, 2024, at 11am.

   Lisa Tomasso (HARI) asked Shamus what the experience has been in comparison to what was anticipated relating to determinations of households with children.

Shamus noted that from a Rhode Island specific perspective, the process is going very well. Consumers continue to voice challenges accessing the DHS call center. He added that the volume has gone up significantly, but the impact will not be known until the end of the month. He further added that a very high number of renewals for children are being done passively.

3. **November Data Story**

Acting Commissioner, Cory King provided a brief overview of the objective of the new data story series. He noted that the office has more capacity to understand and analyze collected data and disseminate that information on a monthly basis. In short, digestible formats he hopes to show how health care spending impacts consumers. He then reviewed the November Data Story titled 'As Health Care Costs Rise, Employee Wage Growth Declines.' He commented on the idea that health insurance is a form of non-wage compensation and from the employer perspective, if health care costs are rising, they cannot offer their employees much of a pay bump as they otherwise might. A survey from employers found that rising costs crowds out wage growth. Al Charbonneau provided the following resource: National Alliance for Healthcare Purchaser Coalition. In Rhode Island, health care spending grew between 2020 and 2021 at a rate of 9.7%, in relation to other states at the same time it is lower. He further added that OHIC will continue to track and measure spending growth.

4. **December Data Story**

Acting Commissioner King reviewed the December Data Story titled 'High and Increasing Prices Drive Prescription Drug Spending.' The data provided was collected from the Rhode Island All-payer Claims Database. He noted that through this database the office is able to categorize drugs into generic and brand and look at the percent of overall spending that is consumed by brand drugs. Brand drugs represent 12% of utilization but 81% of overall spending in the yearlong study. Additional data and dashboards are available to review on the OHIC Data Hub. Future topics include a deeper look into brand drugs, hospital prices, and care migration patterns which include Rhode Island residents seeking care in neighboring states.

Sandra Victorino asked if there would be a breakdown by specialty within the care migration data. She further added that some behavioral health practitioners are going to other states as they pay more. He addressed that in the future there will be a dashboard available by specialty on the OHIC Data Hub. He added that when looking at the totality of spending associated without migration, it tends to be concentrated in a couple of specialties and one state. He noted that there is an obligation to use data and disseminate it to general audience for understandability, he hopes for a more data driven discourse in Rhode Island. After about 5-6 months the stories will be reissued, in the event that bills are introduced that may relate, this available data will be useful. These data stories are available through the email subscription made available through Constant Contact and also housed on the OHIC website.

5. **Primary Care in Rhode Island: Current Status and Policy Recommendations Report**

Cory King proceeded to review the next agenda item; the Primary Care Report recently released by the office. He cited a news article about difficulties in finding a primary care in Rhode Island. In the late 2000's, RI was a leader in developing a primary care expenditure target, convened a multi-payer patient centered medical home collaborative, transformed many primary care practices into PCH's. In February, he conducted a strategic reevaluation of OHIC's primary care strategy. Working with Bailit Health they developed a work plan and an interview guide. Through the interview guide they hoped to speak with providers and payers about what may or may not be working with OHIC's current initiatives, challenges, and what OHIC may be able to do. Interviews began in May and continued over the summer; in October a first draft of the report was completed. This draft distilled what was heard from local parties, examined the trends in data on primary care workforce, clinician burnout, quality, and payment reform from both a national and local perspective. With the established regulatory lever of increasing primary care expenditures using their oversight of commercial insurers, it was a lever that was accepted within the community and can and should be pulled again. During the process, OHIC reviewed primary care spending data and old legacy methodology. Early this year, OHIC will be in a position to make amendments to the powers and duties regulation to change how they measure primary care spending and set new targets, in a way that additional supports go to primary care providers and clinicians. The Acting Commissioner calls specifically for increased reimbursement and increased payment. The other area that came through very clearly was the administrative burden that providers face particularly from prior authorization practices. This work has been ongoing through the Administrative Simplification Task Force. Upon completion of those meetings, he will be prepared to put structure around how prior authorization is applied. He is interested in creating some guardrails around what services should and shouldn't be on the list subject to prior authorization. In addition to changing the primary care expenditure requirement and addressing administrative burden particularly around prior authorization he would like to convene a public body comprised of providers and insurers to meet periodically to discuss administrative issues. He outlined that the office will be advocating for policies that expand primary care workforce training in the state. They will also advocate for policies that other agencies can adopt to ensure and better understand the composition of the workforce. The office will also be ensuring that they maintain dialogue with providers and hold themselves accountable to use the regulatory levers available in order to support primary care. This will be done through the convening of the Payment and Care Delivery Advisory Committee and bringing data collected from insurers to review within the committee. He concluded that this will be a multiyear process of increasing the primary care expenditure target and there is a workplan in place.

Sandra Victorino commented that culturally and linguistically appropriate services is something that hasn't been done well enough. For medical interpreters all the way to language-concordant care. In order to meet the needs and make sure people are following

through with their care, they need to be met where they are culturally as well. Those are two missing links that she has seen as a professional in the behavioral health field.

Cory added that this is an area where the workforce development work that EOHHS has been doing and RIDOH's desire to create data sets that capture more attributes about the workforce will come in to play. He further added that OHIC will not be able to solve all problems but will continue to focus on the policy levers they have largely around money and controlling burden.

Hub Brennan applauded the work OHIC accomplished with the report, adding that the report touched all the necessary bases. He applauded the focus on the administrative burden experience by providers. He further added that the report is representative of what plays out in the day-to-day operations, which can be frustrating and time consuming to all staff.

Cory commented that, from a regulatory perspective, if guardrails are created and consistently applied across all insurers. One plan cannot accrue a more competitive advantage.

Mark Jacobs added that the document is superb, adding that he was impressed with how comprehensive it was, in addition to the recommendations proposed. He additionally remarked that primary care is in crisis, and despite best intentions he does not think incremental changes will help the system. He noted the salary differences and demographics of primary care. Adding that such a significant portion who can or will retire will do so due to the current state of practice. There is a seven-year lag between training a medical student and becoming a provider. Which he does not think primary care has the capacity for. He thinks there needs to be fairly drastic measures, in line with most of which was suggested in the report, although he is not sure how to implement. There needs to be a significant increase in salary in conjunction with a significant decrease in the administrative burden experienced by such providers.

Cory stated that he wrote parts of this report based on this feedback. The evidence is clear about the impact of primary care on health care system performance, health outcomes and cost. In his position as a regulator, he cannot also be an advocate, but he can present this information to people that are able to advocate based on this evidence-based report.

Dan Moynihan mentioned that there is both positive and critical reaction from providers. One of the frustrations has to do with having the funding for value-based care infrastructure, and how funding can be directed towards salary. The infrastructure has greatly increased the quality of primary care, but it has not translated into salary increases specifically for primary care providers. Which is the part they are trying to solve, in order to compete with other markets and specialties.

Cory responded that, as an example, a system like Mass General Brigham, currently suffering primary care capacity issues, will get very direct with their hiring practices. He adds that Rhode Island has to become incrementally more competitive, although he does

not think Rhode Island will be able to match. This because the economies are different, neighboring states have a higher per capita income, household income. Although, the salary and pay will need to be addressed. He was intentional in writing the recommendations within the report that include increased payments. These should be achieved through increased reimbursements for evaluation and management and other medical services, when provided by a primary care provider and through capitative arrangements. He further added that when the office reviews how primary care spending is measured, and how payments are counted towards the spending obligation, it has to be very clear to the insurer what services are credited as primary care. Currently insurance companies are given credit, as primary care spending, for the money that they pay to support the Health Information Exchange. Cory does not know that this should still be credited as primary care spending. In the original iteration of this, there was this idea that there should be a state Health Information Exchange built to support the dissemination of health information across the delivery system, in which insurance companies committed funding to it, and in exchange were given credit for that. He stated that an expenditure lever can be used as a policy lever. What should be credited towards primary care spending is the type of analysis, that the office has been doing and evaluating.

Hub mentioned that it might be wise to ask, if this funding impacts the primary care workforce, if not then it should not fall into the category. He added that payers are important partners, but the focus needs to shift to the primary care workforce issues.

Dan commented that this differs from what the lens was before which was what investments could be made to help primary care manage populations. The investment in the Health Information Exchange made sense, but the focus has changed, and these investments do not translate to salary.

Mark added that it was a tool for care coordination.

Cory noted that the call was made fifteen years ago, which is why it's important now to refresh the strategy and recalibrate how to measure primary care spending through setting new targets. The office is making methodological changes, under the legacy methodology, reviewing paid claims to primary care providers, reviewing where percentages may change. This will happen through a public rule-making process. Since the regulations were adopted several years ago there have been some changes to the rulemaking process. He encouraged members to read the report and submit feedback regarding.

Al mentioned that he thinks it is appropriate to raise primary care, so it hits the pocketbook of the providers. He added that it can't stop there and the day-to-day operations in the office are also problematic, driven by the fee-for-service system. As an example, prior authorization in his mind, is a function of fee for service, if this was paid in a different way it would lead to a different working environment and the incentives and payments would change. On the business community side of things, there is a PPO benefit structure. There is a need to keep focus on not only paying more but also arguing

for a better system. He added that in an ideal world, the physician community would talk to the business community to educate on the benefits they really need, and what would make a big difference in terms of appropriate utilization.

Mark mentioned that this goes back to the birth of Accountable Care Organizations. There were two types to be envisioned, one was a physician centric ACO, and the other was a hospital centric ACO. Physician centric ACOs do not need outside prior authorization or oversight. In those instances, the primary care provider controls the premium dollar, makes wise decision based on it, while also keeping in mind quality measures but the money is parsed on behalf of the patient. Hospital centric ACOs operate differently, and it is very clear that this system predominates as it has the access to capital and the ability to fund infrastructure. He further added that here have been fewer and fewer successful physician centric ACOs. If the clock could be rewound and they could control the premium dollar and disburse it related to patient needs, a lot of the problems could be solved.

Hub reported that he is a part of a one-hundred-and-fifty-member primary care physician organization. Through different endeavors they seek to move payment to primary care providers away from fee-for-service and toward alternative care models. These models include quality metrics that are nationally accepted. This arrangement includes finding efficiencies within the budget and splitting the savings. This group has been very successful in this limited risk model, producing high quality as well as meaningful return revenue in terms of shared savings. He noted that private practice has around 20% additional revenue from non-fee-for-service. The group contracts with payers, those which OHIC has purview over. In the process, they have worked hard towards quality, bending the cost curve, and making it sustainable. He stated everyone was paid except the primary care provider. The return was contracted to come but did not come. He further commented that they were acting as an obstacle rather than a partner, as contracted, letting all of their efforts down. There is a need for payer partners who are truly partners and conduct themselves as partners. He ended with, timely payment commands a significant portion of overall earnings, and that it is not an isolated issue.

Cory did contact and discuss with the insurer in regard to the issue at hand.

6. **Public Comment**

There were no public comments made. The meeting was adjourned at 5:35pm.