State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
April 16, 2024, 4:30 P.M. – 5:30 P.M.
1511 Pontiac Avenue
Building 73-1
Cranston, RI, 02920-4407

Attendance:
Members:
Chair Commissioner Cory King, Al Charbonneau, Hub Brennan, Shamus Durac, David Feeney, Eugenio Fernandez, Bob Hughes, Dan Moynihan, Teresa Paiva Weed, Lawrence Wilson

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

Not in Attendance
Catherine Cummings, Jocelyn Foye, Mark Jacobs, Laurie Marie Pisciotta, Sandra Victorino

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

2) **Rhode Island Parent Information Network (RIPIN) RIREACH Update**
   Shamus Durac of RIPIN provided the HIAC with an update regarding Medicaid determination renewals. Nearly a full year of Medicaid determinations have been completed. They do anticipate some challenges with the second year of determinations approaching.

   Ground ambulance surprise billing was not included in the Federal No Surprises Act. Which prohibited surprise billing for air ambulance and auxiliary services (e.g., anesthesiology, radiology, etc.). Ground ambulance is complicated largely due to how it is administered and comprised, as they are operated by municipalities. RIREACH is continuing to review this and keep an eye on it.

   Additionally, there has been a small but noticeable increase in enrollments in non-traditional health insurance plans, which are licensed to sell products in Rhode Island but are misguiding consumers. Consumers believe they are enrolling in full minimal essential coverage plans. They have worked with Healthsource RI to enroll these individuals in full minimal essential plans.

Teresa Paiva Weed added that everyone has done a great job regarding the renewals, and recertifications. Regarding the non-traditional plans there was talk at the federal level surrounding enforcement. She mentioned that these plans were supposed to be short-term fill in the gap plans. With the duration of these plans not intending to extend further than six months. Additionally, she mentioned that there has been publicity about $36 million Medicaid out of state payments.

Shamus advised that there was a recent federal ruling limiting the non-traditional plans to four months. He outlined that many plans were out of compliance, even before the most recent federal ruling. Regarding payments for out of state enrollees, he does not have a full response. Although, it has been clear over past years that Medicaid has put more into data acquisition to gather necessary information such as residency and income information. He noted that it takes time to get processes right and there has been substantial progress to date. RIPIN has weighed into concerns regarding approval processes.

Teresa noted that they were going to focus in on additional income verification.

Dan Moynihan mentioned that across all facilities, there has been a substantial increase in write-offs for charity care and self-pay. There has been a remarkable increase in uninsured patients, and also patients with high deductibles that cannot afford to pay.

Shamus mentioned that ensuring addresses are up to date is vital. Most consumers only find out coverage is no longer valid at the point of service. Data acquisition surrounding additional income and address verification is in progress. He added that it is equally important to get Rhode Islanders engaged.

Al Charbonneau mentioned one of the first reports has been published from the National Alliance, a group of fifty coalitions that the RI Business Group on Health is a part of. The report found that the current amount that the arbitration is set at, most are following through to arbitration. He also noted that the idea of surprise billing was to hopefully push providers to be in the network, although the experience is not going the way it was intended.

Dan mentioned that from a Lifespan perspective, they have not gone into arbitration, and it is very rare that they are out of network. He added that the emergency room doctors are not employed by lifespan but rather Brown Emergency Medicine, so there may be some instances where those providers are out of network for certain payers. The fear is that some payers may weaponize the rule.

Cory commented that prior to the Federal No Surprises Act, OHIC did not see a lot of complaints. Within the past two years, OHIC reviewed a material change negotiation from United Healthcare to end their contract with Brown Emergency Medicine. This

application was denied as they were the only emergency medicine group staffed within the emergency department at Lifespan facilitates, and there were concerns regarding network adequacy.

Hub Brennan asked if they have looked at the magnitude of prehospital insurance billing and the cost impact on spend and ground ambulance billing. He suspects the numbers are real.

Teresa noted that cities and town bill insurance for the ambulance rides. They collect for out of state residents but do not bill for in state residents. She mentioned that Hub is correct, it is a significant income source for the cities and towns. She added that Medicare Advantage rules pertaining to ground ambulances are difficult for consumers to understand. She wonders if there is a certain product where it is seen more often.

3) **Affordability Update**

Commissioner King outlined that OHIC measures total healthcare spending for the state, and those results are then compared to a cost growth target. On May 13th, the next annual report will be released in conjunction with a public forum at the Crowne Plaza from 9AM-12PM. Cory will be joined by David Seltz of the Massachusetts Health Policy Commission (HPC) and Dr. Deidre Gifford from the Connecticut Office of Health Strategy. They will discuss affordability initiatives across the three states. OHIC will also be releasing five additional dashboards on the OHIC data hub, these include: Care Migration for Outpatient Chemotherapy, Care Migration for Inpatient Admissions, Chronic Conditions, Emergency Department Visits by Severity, and Inpatient Trend by Diagnosis Related Group (DRG). He also mentioned that the RI foundation co-funded by BCBSRI worked with Lifespan, Care New England, and South County Health to publish a study looking at the financial structure of Rhode Island's health care delivery system with a focus on hospital-based health systems.

Copies of written testimony submitted by OHIC on Senate Bill No. 2722, (companion House Bill 8072) were provided to all attendees. The Commissioner outlined that fundamentally it modifies OHIC's powers and duties, makes changes to statutory purposes around guarding provider solvency, it also proposes to advance health equity. It effectively repeals components of OHICs affordability standards regulations, notably the hospital price growth cap and it also repeals the ACO budget growth cap. It creates a price floor for hospital services, physician services, and advanced practitioner services. That rate floor is defined as the average reimbursement matching Massachusetts and Connecticut. It rebases rates to that floor over a three-year period. Every three years through OHIC regulation, it would require commercial payers to at least match that rate. As it is presently written he has significant concerns, he understands the place it is coming from regarding the financial viability of provider groups within the health care system. Although, he advocates for a more targeted approach.

Hub added that it is a quite a fascinating paradigm here, the intercept between access and affordability. He questions at what point does restricted access tip the scale. He thinks access will rise up on the attention spectrum and become a more prevalent issue. The other thing is that we have learned in the past decade that in the delivery of healthcare, that in primary care settings there is no room for profiteering. You cannot have corporations pulling large revenue between the premiums and delivery of services. If the hospital were to need to pull from that revenue stream for operating costs, it is so fickle that there would be very little room to do so, if also keeping the access and care quality intact.

Cory would like more timely data on access to care. Currently, health insurance companies are required to have providers attest to the accuracy of the information reported in the insurer directory on a quarterly basis, which should include if they are currently accepting new patients. Additional data directly from the providers would be more helpful, then could be a more data driven approach to focus on access to primary care services. Senate Bill 2722 focuses on the commercial market segment, includes a significant government section, but he thinks there needs to be a focus on Medicaid rates. He does not want to be at a place where people cannot obtain timely access to care.

Al commented that pertaining to access and primary care, he would advocate for paying primary care more, though he would attach conditions to it. One of those conditions would be to discontinue the fee-for-service model. He mentioned as an example, a practice in New York switched from fee-for-service to team-based care and saw an increase in recruitment of providers. This is an instance where providers are practicing to the fullest potential of their licensure.

Hub wonders with Medicare advantage to go full risk, what relief that really brings, it is a significant paradigm shift. He is interested to see how that effects these issues.

Teresa mentioned that the legislation raises an important issue in terms of reimbursement on the Medicaid side. South County health has a payer mix of Commercial and Medicare, but it does not solve the problems of the hospitals. The fact of the matter is, that primary care is being secured in the emergency rooms because they are open 24/7, including weekends. For them, Medicaid reimbursement is the primary issue, not primary care because they are providing primary care. Federally qualified health care centers need to look at that Medicaid side of the equation for primary care, to have any real relief. If it is just the commercial side; it won't help relieve the burden in the hospitals. If choosing to champion primary care and access, there should be conditions.

Hub agrees with Teresa and adds that there would be no minute clinics if providers worked 24/7. Relative to the Medicaid position, it speaks directly to health equity.

Cory mentioned that Senate Majority Leader Pearson has a bill that adds to primary care to the scope of OHIC's Medicaid rate review process, which he supports. He also added that last week the Governor filed a budget amendment pertaining to the rate review process. OHIC's Medicaid rate review was rewritten into a new chapter of general laws which codified some decisions around the methodologies used for the rate review. He mentioned the changing of the some of the timelines and cycles of the rate review, which will be discussed with the legislature. Notably, adding primary care to the scope. There are two avenues to get primary care within the current OHIC Medicaid Rate Review: if the General Assembly does not act upon the budget amendment, the bill advocated by Senate Majority Leader Pearson is there. If the General Assembly does act on the budget amendment, primary care will be included in the scope. The Commissioner gave Secretary Charest credit regarding the importance of including primary care.

4) **February Data Story**

The February data story titled *'New Research: More Evidence that Rising Health Care Costs Crowd Out Wage Growth'* focused on the high and rising health care costs affecting Rhode Islanders. Cory wants OHIC to be the hub for data on health care spending and utilization. As part of the cost trends works, they are issuing monthly data stories with data taken from the All-Payer Claims Database and academic literature. These findings were taken over a thirty-year time horizon focusing on wage growth, wage stagnation, and income inequality by race. Employer sponsored health insurance is how health insurance is delivered to the majority of consumers, it is the employees' compensation. It is that trade off that economists have begun to quantify. Income is not growing as fast as it would if health care coverage premiums were not increasing at the rate that they are. There is an economic dynamic that people need to be aware of, they see how much comes out for the health insurance, but they do not see the amount that the employer contributes to that.

5) **March Data Story**

The March data story titled '*Mental Health Services Utilization on the Rise in Rhode Island*' focused on the increased utilization of mental health services among Rhode Islanders with commercial insurance. Using the All-Payer Claims Database, OHIC has public facing dashboards where consumers can view trends in spending and utilization. Additionally, consumers can view changes in spending on mental health by age group, increased utilization in youth seeking mental health services. There is a noticeable uptick of providers utilizing telehealth, behavioral health providers have really utilized this approach. Per member per month increases were substantial but are not driven by reimbursement rates but by increased utilization. It does not consider patients who pay out of pocket for out-of-network providers. There could be additional conversations surrounding network adequacy and why the providers would not participate. He commended Richard Glucksman from BCBSRI who worked hard to get the All-Payer Claims Database set up. He would like to test it to see if it can start to be used for certain

insurance company reporting functions. It would require getting additional data from the insurers, but they may be able to get it to that point.

Teresa commented that she always thought the All-Payer Claims Database was underutilized.

Lawrence Wilson asked, how can this group help sustain this type of work, as seen in the data stories.

Cory acknowledged that right now it is in the OHIC resources. Although the budget has grown significantly, with the addition of the Medicaid provider rate review function. He has been providing content that he thinks is interesting and helpful to consumers and hopes to continue the resource. Upcoming data topics include prescription drug spending and pharmacy rebates. He asked members to put forth any ideas that they are interested in seeing. He added that as part of the cost trends work, there was a data analysis subcommittee which included experts that advised them on the types of analyses that should be conducted.

Teresa mentioned the topics of denials and prior authorization. Additionally, she mentioned the feasibility of a study of the administrative costs related to such functions. Nationally, there is a company quantifying the administrative costs of denials and prior authorizations. There are cost savings to be secured. Looking at hospitals alone, how much time, money and energy is being spent on denials and prior authorizations.

6) **Public Comment**

There were no public comments made.
Cory King, Commissioner and Chair adjourned the meeting at 5:30PM.