State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
September 17, 2024, 4:30 P.M. – 5:30 P.M.
1511 Pontiac Avenue
Building 73-1
Cranston, RI, 02920-4407

Members in Attendance:
Commissioner Cory King, Hub Brennan, Al Charbonneau, Howard Dulude, Shamus Durac, Eugenio Fernandez, Bob Hughes, Mark Jacobs, Dan Moynihan

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

Not in Attendance
Catherine Cummings, David Feeney, Jocelyn Foye, Laurie-Marie Pisciotta, Sandra Victorino, Lawrence Wilson

1. Introduction and Review of Meeting Minutes

Commissioner and Chair, Cory King called the meeting to order at 4:30PM. Howard Dulude, Interim President at HARI introduced himself and Cory said a few kind words about Teresa Paiva Weed, who recently retired as President at HARI. Cory introduced Charlie Estabrook as the new Director of Policy at OHIC. Members voted to approve the May meeting minutes.

2. Rhode Island Parent Information Network (RIPIN) RIREACH Update

Shamus Durac provided the RIREACH update, there are no major trends to be reported. He invited members of the group to share any concerns or notable trends that consumers may be facing. He provided a brief overview of RIPIN (Rhode Island Parent Information Networks Consumer Assistance Program known as RIREACH. The system is all payer, and available to assist anyone experiencing Rhode Island related health insurance issue or concern. The program is also available to those who live outside of RI but participate in RI based coverage. They work across the health care delivery system, assisting individuals with Medicaid, Medicare, commercial insurance and those with no insurance. As of 2017, the program has saved Rhode Islanders 8.8 million dollars on a budget of 2.6 million dollars. Over the years, there has been a significant increase in work around Medicaid eligibility and utilization of services in tandem with the Medicaid unwinding following the COVID-19 pandemic.

Dan asked with the results of the unwinding, is the program seeing an increase in uninsured individuals.

Shamus noted that it was mixed. He added that they were landing in a better place in terms of coverage than they were leading up to the pandemic for a number of reasons. Some of which

including ongoing initiatives, such as the states work on using external data sources to verify income for Medicare enrollees. At one point, an individual had to manually report their income annually, leading to increased administrative burden. Now, a majority of the population and a significant majority of the Medicare population can have their coverage renewed annually because the state has access to data systems to verify income and assets. The number of people experiencing administrative terminations has also decreased significantly which helps reduce the rate of uninsured. He also added that HealthSource RI has done significant work in increasing communication to affected individuals, in addition to assisting individuals seamlessly transition to other types of coverage, if necessary. In comparison to other states, Rhode Island is doing well in that regard.

Howard noted that the cost for state only funded Medicaid coverage is increasing significantly.

Shamus explained that he did not have the specific numbers to support but that the numbers had stabilized recently. From his understanding the concerns had been abated by the states recent work in identifying individuals qualifying for federal funds.

Dan asked if those benefits go through the MCOs.

Shamus noted that these individuals would be able to be enrolled in MCOs.

Eugenio inquired about available data between the fee-for-service Medicaid and the MCO in terms of Medicaid spending.

3. Affordability Update

Cory outlined two pieces of legislation passed during the 2024 session that impact the office. The first bill, House Bill No. 7365A surrounds the practice of white bagging. This bill tasks OHIC with conducting an analysis of the payment for clinician-administered drugs starting January 1, 2025. The second bill, House Bill No. 7944A, requires dental insurance carriers to file actuarial memorandums to assist the Office of the Health Insurance Commissioner with respect to a report of recommendations regarding dental insurance loss ratios. He explained that in medical insurance the federal government has a loss ratio requirement under the Affordable Care Act for individual, small group and large group. In the individual and small group markets, if the carrier spends less than 80% of earned premium on patient care, and less than 85% for large group, a rebate would be paid to the consumer. He further explained that it is technically a three-year moving average of MLR data but effectively it it is intended to cap administrative costs. In Massachusetts, dental providers advocated for a ballot initiative that created an 83% MLR for dental insurance but to his knowledge it did not detail the elements of that calculation. In Rhode Island, there had been legislation introduced to create a MLR and rebate for dental insurance that received a lot of attention and submitted testimony. Ultimately, a compromise passed where OHIC would bill the dental carriers for up to a three-year period to hire an actuary and do an analysis in setting a minimum loss ratio in the state. OHIC will collect data on the incurred claims, premiums, and additional components and then report to the General Assembly in 2026 with recommendations around setting a loss ratio for dental. Cory emphasized that he is not opposed to a loss ratios in dental, but he wants it to be a data driven process.

Cory additionally provided an overview of the Social and Human Services Programs Rate Review, which includes Medicaid rates for certain provider types. OHIC proposed amendments to the process, as currently the review of all in-scope services is done every two years. OHIC proposed to break down the scope into a four-year period and complete a quarter each year in addition to adding primary care to the scope. That bill did not pass. There was also a separate Senate Bill that took current law and added the words primary care to it, which also did not pass.

Al emphasized that the dental bill is a reoccurring bill, that he first provided testimony a couple of years ago. He also supports additional data driven analysis. He then provided an update on the $300,000 grant awarded to the Rhode Island Business Group on Health by Arnold Ventures. Early in his career he learned of the Medicare cost reporting, which he has presently done additional work in. With the assistance of Arnold Ventures, he has developed a model of the cost report to look at the big picture. Notable trends have been seen in the hospital's overhead costs within the last 15-20 years. The database now has approximately 120 million rows, and two reports have been published thus far. The reports can be found on the RIBGH website, also linked here. The next report will focus on system information, including expense information on a per capita, and per discharge basis. Additionally, he has been working with faculty from the University of Rhode Island College of Business and Analytics to apply some of the business analytic models to the database. The next iteration will be shared with the hospitals.

Howard asked what implications there were for hospitals related to administrative costs with insurers such as utilization review (UR), denials and appeals processes. He mentioned the work AHA and HFMA have put out using cost reports for that type of analytics. He will share this with the group at a later date.

Al discussed the SERFF data and detailed that the number of subscribers in small and large group commercial insurance has gone down 50% over the last 10-12 years.

Cory communicated that he has also seen the decline. He mentioned the possibility of a market merger between individual and small group, in addition to the possibility of regulating stop loss insurance more aggressively. He noted that he has observed an increase in larger employers going self-insured. In the market stability workgroup, a survey concluded that newer small businesses tend to not offer insurance at a higher rate. The leading reason for smaller employers to not offer insurance was the cost and the leading reason for the employers to offer insurance was to recruit and retain employees.

4. 2025 Health Insurance Rate Review

A copy of the press release was provided to all attendees. Cory outlined that the rates proposed for 2025 were the most consistently high across health plans that he has seen in his tenure at OHIC. He commented that he thinks a lot of it is driven by Blue Cross as they are 70% of the market. He noted United Healthcare's small group market has been decreasing over the years. Rate filing is the insurance companies' projection of revenue needed to garner premiums. They are projecting that revenue requirement based on history of claims, utilization, expected and agreed to contractual price increases, and new prescription drugs. Consistent with past years practice, OHIC reviewed the filings. The Attorney General also hired actuaries to conduct

reviews. He detailed that the Blue Cross individual filing, the rate was over 10% which required a rate hearing to be held. He advised that under these approved rates, individuals and small businesses are going to see an additional hundred million dollars in premium costs. He was able to modify some utilization trend assumptions and disclosed that this year, for the first time OHIC imposed an inflation cap on insurer administrative cost increases across all markets. If an insurer filed a per member per month administrative charge higher than the previous years per member per month administrative charge above inflation; OHIC only gave them inflation (3.3%). In some cases, they also reduced the contribution to the reserve margin. He noted that there is some consistency if you look at the OHIC approvals and RI AG actuarial recommendations. Weighing affordability, the funding needs of the health care system and solvency for insurers is a balancing act. Given the data, the evidence, and the statute, Cory explained that this was the best result that could be achieved this year.

Hub appreciates the balancing act. His concern is that the market with utilization having not peaked but risen and sustained post covid, that insurers will still suffer significant losses. Although, this could be used to deny claims and lower reimbursement. To enter a risk contract with a payer that is projecting significant losses is a loss to the entity immediately when signing. With all of the work done to move away from fee-for-service, the state of the market might still be disappointing. He thinks risk contracting should be the first thing to be put on hold and asked the Commissioner his thoughts on it.

Cory acknowledged that that is certainly a risk and added that there are components of potential downside risk that he thinks the ACOs, and the insurers need to be more thoughtful of when negotiating. For instance, certain high-risk drugs. He also noted that relying too heavily on shared savings to compensate primary care is not a sound practice and should be looked at in changing. He also explained that there are protections built into risk sharing around risk sharing caps.

Mark added that utilization cannot be controlled in an inefficient system. In fact, he thinks more utilization of the right kind would be beneficial. His question is to what extent and what role can OHIC play as a catalyst in restructuring the system and enact change.

Cory commented that they don't want there to be an inappropriate amount of control of utilization, explaining that there is under use and then there is misuse. The one thing that health care entities can control at the beginning of the year (before any services are rendered and prescriptions are written), is the reimbursement, or the price per unit. If utilization goes down, and the prices go up there can still be a net increase in premiums. While reviewing the MEPS data (Medical Expenditures Panel Survey), he found that Rhode Island's premiums are statistically significantly lower than every New England state for 2023. While looking at the MLR (Medical Loss Ratio) data for all fully insured plans, Rhode Islands premiums are lower than Massachusetts and Connecticut. Without adjusting for actuarial value, looking strictly at what the market pays on a per member per month basis. He thinks they need to manage price, pharmaceutical prices, keep an eye on hospital price growth, and increase primary care rates. Funding primary care through hospital operating margins is not the way to fund primary care.

Dan added that the one price they cannot control is pharmaceutical and how much is pharmaceutical spending driving it. From an ACO perspective, as the health plans go so will the ACOs.

Cory added that if drug prices could be lowered by 25%, there could be a net savings to the consumer and the ability to reallocate funding. He thinks there are some savings in administrative costs.

Eugenio commented that pharmaceutical companies may be out of reach, but perhaps it would be worth considering the subcontractors the insurance plans use (Pharmacy Benefit Managers) in order to better understand the rebate fee system.

Howard asked what incentive there is for the provider to engage in shared savings programs.

5. AHEAD Model Update

Cory thinks it would be interesting to hear from the ACOs at a future HIAC meeting. He provided a brief update on the AHEAD model. Rhode Island submitted the application before the due date. The state received questions and are working to respond to those questions. He hopes to bring additional updates soon regarding the application status.

Bob mentioned the new medical school, and thinking creatively what Rhode Island can do to segment that.

6. Public Comment

There were no public comments.

The meeting was adjourned at 5:35pm.