State of Rhode Island Office of the Health Insurance Commissioner
Health Insurance Advisory Council
Meeting Minutes
March 18, 2025, 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, Catherine Cummings, Howard Dulude, Shamus Durac, Eugenio Fernandez, Mark Jacobs, Dan Moynihan, Ira Wilson

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

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

1. Introduction and Review of Meeting Minutes

Commissioner and Cory King called the meeting to order at 4:30 PM. Present members voted to approve the January meeting minutes.

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

Shamus Durac provided the RIREACH update. The call center fielded calls regarding the data breach throughout the month of January. That volume has been replaced with individuals cycling off Medicaid and looking for commercial plans, individuals looking for Medicaid assistance, and consumers navigating open enrollment. Additionally, there have been additional questions from the community surrounding the future of Medicaid, and its uncertainty. He welcomes members to reach out with any issues or concerns they have seen.

3. Affordability Standards

Commissioner King explained that the office recently finalized the amendments to the Powers and Duties regulation, which incorporates the Affordability Standards. There was a recent email sent out about the finalization, and it will also be posted on the Secretary of State's website. The amendments are effective March 20, 2025. There are two major aspects, both of which are geared towards improving the situation for primary care in the state. The first piece was a refreshing of the office's methods and target setting, and how the office holds commercial insurance companies accountable for primary care funding. Under the new rules, the baseline primary care spend is about 6.4% of the new total medical expense denominator. Over a four-year period, primary care spending will be driving up to 10%.

Based on financial calculations done for the regulatory analysis, the primary PMPM, which includes claims-based payments and non-claims-based payments, is about 35 dollars. This is lower than Massachusetts but higher than Connecticut. The information is based on public data available from the Center for Health Information and Analysis in Massachusetts and the Connecticut Office of Health Strategy. Medicare and Medicaid are significant funders of primary care, in addition to commercial insurance but OHIC does not have oversight over Medicare and Medicaid.

Providers were interviewed in 2023 and one of the main facets of the discussions surrounded administrative burden, specifically electronic medical records and prior authorization requirements. There has been a lot of discussion, over the years, around how the application of prior authorization could be made more efficient. The work that the CTC-RI conducted provided a basis for the Administrative Simplification Task Force. This enabled OHIC to place guardrails for insurers to consider or follow when developing their prior authorization requirements. The rate at which the service is approved over time, the cost of the service, and the administrative burden on providers should be considered when determining the services subject to prior authorization. He explained that Vermont requires insurers respond to a standard set of questions regarding the prior authorization practices, including what factors they consider when developing those requirements. This information is publicly available here.

In addition to setting standards, collecting data in new ways, and collecting attestations, he outlined a new subcommittee of the Administrative Simplification Task Force. The subcommittee would be comprised of providers and payers and will meet at least two times a year to review data and continue the discussions around prior authorization processes and burdens. He emphasized that health plans have begun to take initiatives in reducing the prior authorization burden on primary care providers. Separately, leveraging the work that CTC-RI completed, the office put into regulation that insurers achieve a 20% reduction in prior authorization volume. The office will measure that as a volume per member per month, so it is normalized. He suspects that the data will show some variance across health plans. Charlie Estabrook will be managing the data associated with this process. He concluded that there is still a lot to be done around administrative burden reduction, but he wants to be thoughtful, and data driven about it. He also mentioned legislation introduced that is aimed at prior authorization. There are also some technical changes in the regulation, such as ensuring funding for patient-centered medical homes (PCMH) are not at financial risk in total cost of care contracts.

Mark Jacobs asked how this all relates to primary care rate review, and wonders if he is correct in thinking that the rate review requires legislative approval.

Commissioner King explained that the office has a long-established history of using their regulatory authority through their general statutory authority in combination with the health insurance rate review authority; in order to drive insurance companies toward greater funding for primary care. The mechanisms used to deliver that funding would include combinations of reimbursement, non-claims-based payments, bonuses etc. Historically, the office has never done any kind of rate review for commercial insurance, in terms of provider reimbursement rates. In 2022, the legislature amended the enabling statute which gave OHIC the authority/duty to review

certain types of publicly funded services and the reimbursement rates for those services. This included home and community-based services, behavioral health, early intervention, developmental disability services, etc. More information can be found here. Something the office has advocated for is bringing primary care rates, or reimbursement rates paid to primary care providers into the scope of the rate review. He does not have authority to compel Medicaid to do anything in regard to rates. The office can deliver a report with recommendations, in which they can choose to accept or modify. When the office issued the first report, adopted the recommendations, with some modifications, and it resulted in one of the largest single year increases in Medicaid funding for the in-scope services. The Governor's recommended FY 2026 Budget, Article 8, Section 8 contains the amendments to OHIC's statute that provide the authority to include primary care services in the rate review. He interprets the definition of primary care services broadly to include items like care management.

Mark asked about the timeline of the rate review.

Commissioner King detailed that it is a biennial process. The office is currently in the midst of the second process, making recommendations for in-scope services by September 1, 2025. Primary care would be included in the next round, which would be delivered in September 2027. He also noted that there are bills currently in the House and Senate that would also incorporate rate review for primary care services for Medicaid into the scope.

Mark commented that this work wouldn't help practices that were currently in trouble, particularly the Federally Qualified Health Centers (FQHC).

Howard Delude commented that, providers would first see an increase in late 2028 – early 2029. Additionally, he outlined other bills that have been introduced that provide or require Medicaid to make additional funding to providers.

Catherine Cummings asked that for prior authorization specifically, is there data available for the last time prior authorization was rescinded and did it help primary care providers survive. She also mentioned waivers and some things being done on the behavioral health side pertaining to prior authorization.

Commissioner King noted that one health plan has rescinded prior authorization on behavioral health now for a few years, and they did not put it back on. Vermont recently passed legislation removing prior authorization from a host of categories. This information could be looked at in terms of the impact on health insurance premiums as claimed by the insurers and validated by the experience. He also commented that relating to the temporary waivers of prior authorization during the pandemic, they were delivered at a time when utilization fell, which may confound our ability to draw conclusions about the elimination of PA on utilization and costs. Commissioner King is committed to continuing to host a data driven dialogue between providers and insurers.

Howard mentioned Hub Brennan's previous comments regarding the need to add additional staff members in order to process the increased volume of referrals.

Eugenio Fernandez emphasized that one of the issues with prior authorization is the variability of forms between different payers. He wondered if increased data could assist in developing one uniform prior authorization form to be used for all payers.

Al Charbonneau commented that if not looking at moving away from the fee-for-service system, and if not looking at the contribution that primary care can make by keeping people out of the hospitals, then RI is missing the boat.

4. Legislative Session Updates

Commissioner King previously mentioned the primary care rate review bills, which he encouraged everyone to look at. He also mentioned the Governor's budget. The office will also be completing a legislatively mandated report on whether the state should set a minimum loss ratio requirement for dental insurance. Charlie Estabrook will be managing that. He also mentioned he will be speaking at the House Finance committee hearing on Wednesday, March 19, 2025.

Legislation that OHIC put forth on Medicare Supplement market and rating rules is House Bill 5494, and the companion Senate Bill 610. The bill is an attempt to start a conversation about reorganizing the Medicare Supplement market in ways that expand consumer choice and promote fairness. The major components include moving away from an age-rating system to a community rating system where everyone pays the same, rather than being conditioned on one's age. This is more in alignment with what neighboring states do for their Medicare Supplement policy, in terms of rating. The bill would also allow consumers the ability to change plans without being medically underwritten. Allowing an individual to have an annual open enrollment window where a consumer can revisit the market and see what is available. Effectively, consumers currently get locked into a decision they made at the age of 65. If they want to move to another policy, they are then subject to medical underwriting.

Ira Wilson commented that if you sign up for Medicare Advantage and then decide at the age of 69 because you get sick, you change back to fee-for-service Medicare, you sometimes no longer qualify for a supplement in most states. He outlined that one can in Massachusetts. It prevents people from moving from Medicare Advantage back to fee-for-service Medicare if they can't qualify for a supplement.

Commissioner King explained that the bill's language states "an individual enrolled in the Medicare supplement policy or Medicare Advantage plan that has been covered by any Medicare supplement policy or Medicare Advantage plans with no gap in coverage greater than 90 days beginning from that individuals Medicare supplement open enrollment period, shall annually be afforded guaranteed issue rights for a period of at least 30 days beginning on the individuals birthday, for any Medicare supplement policy or applicable certificate that an issuer currently makes available in this state."

Ira noted that it does sound like the loophole he mentioned above is resolved with this language. He also thinks the issue of moving from one supplement to another supplement is tiny compared to moving from Medicare Advantage to a supplement.

Howard asked if the Commissioner knew what percentage of beneficiaries are on supplement plans versus Medicare Advantage. He additionally commented that a younger beneficiary's rate would probably go up.

Commissioner King noted that over 50% (59.9% specifically) of Medicare enrollees in the state are enrolled in Medicare Advantage. He further commented that it would be impossible to change an insurance market structure without some distributional differences.

Shamus thanked the Commissioner for starting this conversation. RIPIN has some broad thoughts on Medigap, and technical comments that he would be happy to share with the office. One is around the issue of the timing of an open enrollment period being attached to the birthday, but the timing of disenrolling from a Medicare Advantage plan not being tied to the birthday. Going beyond the technical suggestions, he has concerns around individuals being able to access Medigap. There are then things one could do to make Medigap quote unquote open to anyone that would then increase the premiums to the point that only certain people could benefit from them. He is also interested to know, the portion of this that relates to individuals with disabilities who access Medigap (which are limited to Plan A) which is a very limited Medigap plan. In combination with a community rating that could then eliminate any incentive for a plan to be more generous than that, and sort of lock people into a plan that has somewhat more limited benefits.

Howard noted that the Hospital Association has, in essence, three bills that are being introduced. Two of them focus on the state investing in Medicaid, and there is a separate bill that allows the state to take advantage of a rule on the Medicaid side that allows states to issue a provider tax. To then use those dollars to pay Medicaid payments and propose increased payments to hospitals. Right now, it is funded by a provider tax on the hospitals, a little under 6%, and it is a multivariable tax rate. There is an opportunity that the state can increase the money that is available and from his perspective it doesn't cost the state budget any money to do so. There is also an additional bill that suggests, for a three-year period that the state should increase the rate cap on commercial insurance and population health contracts by an additional two percent a year. He also mentioned a previous House Finance committee hearing, in which the Hospital Association pushed back on the proposed budget, because it is actually a cut to hospitals. He additionally commented that if they are not successful on the Medicaid side in bringing in federal dollars, it puts more pressure on the need to increase commercial rates to support everything. If there were to be cuts on the Medicaid side that would also put more pressure on providers to push commercial insurance. It is linked, although separate.

Al noted that everyone should be looking a little bit differently at hospitals and hospital systems. Hospitals will not be able to generate enough reimbursement in outpatient services, to offset the loss in inpatient services. There is a need to put hospitals on a more stable ground.

5. Federal Updates

Commissioner King commented that his primary federal update is the potential changes in the Medicaid program. Federal agencies were on a communications hold for a time. The AHEAD

program, as of today still stands for States Advancing All-Payer Health Equity Approaches and Development. The equity piece will be taken out, but from what he understands it will still be called AHEAD. The critical question for Rhode Island will be if the substantially higher hospital incentive payments they secured will still be offered. Currently, Rhode Island is still prepared to move forward. There does continue to be risks and unanswered questions. The office continues to track other changes out of HHS.

Howard asked when the time would be to start talking to hospitals and providers.

Commissioner King explained that any AHEAD program changes will need to be reviewed, and there may be changes that Rhode Island may not want to accept, thus not proceeding with the program. He opened the discussion for public comment.

6. Public Comment

There were no public comments.

Commissioner King adjourned the meeting at 5:30 PM.