RI Healthcare Reform Commission
Executive Committee Meeting
November 28, 2011
Meeting Minutes

Attendees: Secretary of Health and Human Services Steven Costantino, Director of the Administration Richard Licht, Health Insurance Commissioner, Governor's Policy Director Brian Daniels, Lt. Governor Elizabeth Roberts

I. Call to Order: Lt. Governor Roberts called the meeting to order at 2:00pm on 11/28/11. She advised the members of the presentations that will be covered at today's session and encouraged questions.

II. Risk Adjustment, Risk Corridors, and Reinsurance – Follow-Up Discussion Presentation by Dan Meuse with the Office of the Lt Governor [http://www.healthcare.ri.gov/documents/Risk%20Adjustment11_28.pdf] Discussion questions and comments:

a. Director Licht inquired about the data, and particularly asked about the actuarial analysis, wanting to know if this data reflected the entire population or the uninsured population. He asked if it were possible that those are entirely different sets of data? Mr. Meuse responded that this program affects the individual and small group markets. The APCD would give us data for all populations, but in those two groups and outside those two groups. Being able to analyze our data as a whole would be valuable to see our trends. The Director further inquired, does this affect the uninsured? Mr. Meuse responded that the it is generally anticipated that on Jan. 1, 2014 there will be less uninsured. It is a retrospective look, so that after the uninsured come in then adjust. 2012 sees the creation of the system for risk adjustment – that system will be in place by 2014 when many in the uninsured population come into the system, thus collecting more data and allowing for retrospective data.
b. Secretary Costantino inquired what would the fee be on? There are two models that are discussed – the first could be built into both sides, and in that model the state agency is collecting the fee. It is still self-sustaining model, going to state government, or it would come through an assessment across the exchange.
c. Why is it a legislative requirement? The implementation of the new program in the OHIC would be a statutory addition to his/her duties. If RI adopts the federal program, would RI need legislation? Do not think so. Then why is it needed for a state program? It will be both inside and outside the exchange. Mr. Meuse noted the legal authority to collect data is there, the legal authority to do the analysis is there, but to issue premiums and do the weighting – that is not necessarily

there, thus it's a different authority regarding redistribution of premiums.

d. Are the options to either have a state risk adjustment or federal? Yes, one or the other is required. If it were internal to the exchange, it is mandated by federal law in order to balance things outside the exchange – by federal law, insurers outside the exchange would be mandated to participate in the risk adjustment program as well. This will need further thought.
e. With respect to reinsurance and stop loss for serious illness, can there be a stop loss on the aggregate? If costs get above X, reinsurance kicks in. Mr. Meuse replied that guidance from the federal government and actuaries contemplated this working at the claim level. Reinsurance is only a three-year program, and only in the individual market not in the small group market. Risk adjustment is a longer situation.
f. Suggested tabling the question about legislation being required, but may still look at decision for state program vs. federal program.
g. The members were not clear on the true distinction between federal vs. state, and requested more of a distinction to be brought forward in future sessions.
h. When this presentation went to stakeholders, were there any individuals or groups opposed to a state program? Mr. Meuse noted there was not vehement opposition, yet they had heard requests for more information about timing and guidance. The members encouraged as much participation from insurers as possible –as they would be impacted most by the risk adjustment. There was a bit of concern about not knowing what the federal guidelines were, and "building the airplane while it flies."
i. Director Licht noted that absent vehement opposition, difficult to see why RI would not do its own.
j. Stakeholders had general consensus for location at OHIC for risk adjustment? That was generally accepted.
k. On risk adjustment the landscape seems a bit soft on the value of state vs. federal. Mr. Meuse stated that the staff perspective is that if a state runs the program, and carriers come forward and say this is not working for us, then can adjust if necessary.
l. If the population is being treated for diabetes, and a carrier gets 18% and someone else only get 6% its not the particular cost of treatment that gets weighted – Mr. Meuse noted if RI finds its more expensive to treat a diagnostic code, then that's uniform across the board.
m. Any sense that the national model would be focusing on national rather than regional? Not sure yet.
n. The comment came that the group needs to look at the legal question more closely. Also the scale – are we talking about an investment that costs *n* to run it and it will be *.8 of n* in the federal program? Do we have that yet? Mr. Meuse replied that at this time we do not have a sense of that scale yet, no guidance on what the state requirements

will be. May bring forward to aid in clarification, identify clear examples of where the decision points shift. When the decisions will be made elsewhere and precise order to facilitate a decision.

o. Not completely resolved. Will revisit.

III. CMS Health Care Innovation Challenge – Presentation by State Medicaid Director Elena Nicolella.

a. Is the recipient of grants that you just mentioned is that DHS or is the state of RI? If the latter, it precludes those in this meeting? Yes, all at the table are prohibited from applying, but collaborative partners could get together and do so. The money would flow to a local group; the provider group etc, but there could be a lead agency. Pushing for public-private partnerships.
b. Is there a sustainability requirement? Have to show sustainability after three years.
c. New care delivery and payment models? Didn't use the term ACO as such, but that type of bundled payment for a whole breadth of services, moving away from the traditional fee for service payment model are what CMS is pushing.
d. The networks with DCYF, is this the sort of innovative payment model they're talking about? The examples provided in the funding opportunity are not that revolutionary, it's a lot of what we have already seen in RI. Big opportunity here for state to get innovations going, and where OHHS wants to be supportive is in meeting with potential applicants. There are opportunities from EOHHS to have meetings to discuss/questions etc.
e. Is there any sense that multiple projects per state would not get funded? Payment and Workforce are two buckets. CCIIO is interested in a comprehensive solution vs. five separate issues.
f. Focus on CMS beneficiaries, extent can be supported; assets in the state around Right Care and communities of care; there is a January application date for intent letters.
g. Helpful if in two weeks discussion of what comes out of meetings on this and who is sending letters of interest etc.

IV. Robert Wood Johnson Foundation State Health Reform Assistance Network Program - Presentation by Dan Meuse, Office of Lt. Governor

a. Is this health insurance survey instrument surveying subscribers? This would be surveying Rhode Islanders, working with SHADAC to develop this instrument, the goal being to understand where people may get insurance from, what their health status is, how they're using insurance, etc. Broken down by income levels, types etc. – also folks who aren't insured and where they receive care.

b. For the review of the commercial insurance reform and statutes, is there comparison to other states to see if more burdensome, or have more application, how to comply with Affordable Care Act? It is more what is in the scope of the product to comply with the federal act – to compare with other states.
c. Statewide health plans $150K, as well as a technical assistance vendor that may piggy back on that amount.
d. Emphasize expansion of access - flexibility and responsiveness is significant.
e. Health homes initiative at BHDDH and CEDARRS was approved. These long term care initiatives to be discussed with the Executive Committee in January
f. Announcement: the state has been nominated to be one of six entities in the world for an award on wellness and corporate wellness programs and the presentations will be made in Rome this weekend for state employees wellness programs. Three in the US, RI being one.

V. Public Comment:
a. Elaina Goldstein: URI is working on the Healthcare Innovation challenges, with a meeting scheduled for next Friday. Emphasize the desire to coordinate
b. Richard Langseth: Bring to attention a whole group of people out there who need to be communicated to. Article in today's paper by Ben Woofer, noted that young people throughout the state engaged in different ways, through social media, and believe it was important to reach out via social media. Mr. Langseth made a point about his recent registration of a website allpayer.com, no states have registered this yet. Be sure to reach out. Concerned that there should be more of a community piece to the media
    i. RI Health Coverage Project was cited as a new consumer group being created that will likely address some of his concerns.
c. Dr. Tsiongas: Don't recall from the Expert Advisory Committee if firmly gelled on putting risk adjustment at OHIC, though may have missed it and personally agree OHIC would be a good place. Concern that the exchange is still being perceived as a Travelocity of healthcare. Thinks it is still conceivable to consider housing risk adjustment where house the Exchange is housed– the Exchange does not need to be too narrow, and risk adjustment may be the first piece that may not work well. For those of us involved in the recent processes with the Health Care Reform Commission there is a lot of bureaucracy, and we face more with each new layout of the ACA. Argue that while doing this we also think on a larger scale, not just in the weeds. Consider a modest proposal, such as get down to three regional hospitals in the state of RI. Can do things outside of the ACA to move reform forward.

VI. Adjourn – Lt. Governor Roberts adjourned the meeting at 3:30pm. Next meeting on December 12 at 2:00pm on the Basic Health Plan.