

The Senate Commission on the
Impact of Health Plan Patient Liability Provisions on
Access to Healthcare and
Provider Financial Condition

Findings and Recommendations

Report Submitted

April 2015

TABLE OF CONTENTS

Commission Membership	1
A Letter from Senator Joshua B. Miller and Senator Louis P. DiPalma	3
Introduction	4
Executive Summary	6
Commission Findings and Recommendations	7
Commission Meetings	
Addendum 1: Joint Resolution S3133 Creating a Special Legislative Commission to Study the Impact of Health Plan Patient Liability Provisions on Access to Healthcare and Provider Financial Condition	
Addendum 2: Hearing Notes	
Addendum 3: Meeting Agendas, Presentations, and Handouts	



Commission Members

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Co-Chairperson

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Michael Souza
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Michael Dacey, MD
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Matthew Harvey
RI Executive Office Health & Human Services

Marc A. Proto
Lifespan Hospital System



Dear President Paiva Weed:

We are pleased to present the findings and recommendations of the Senate Commission to Study the Impact of Health Plan Patient Liability Provisions on Access to Healthcare and Provider Financial Condition. This seventeen-member Commission consisted of dedicated professionals representing insurers, health care providers, hospitals, the business community and public officials. We would like to express our sincere gratitude to all Commission members for their willingness to take part in these discussions, and we appreciate the time and talent they graciously provided.

The Senate Commission was convened to study and make recommendations regarding the impact of significant patient liability provisions within health plans (to include coinsurance and deductibles), and individuals' and employers' desire for choice in the cost of coverage resulting from different levels of patient liability and their relationship to a person's access to healthcare, health insurance, personal financial well-being, and the financial condition of healthcare providers.

This final report is the culmination of the hearings and discussions that began in October 2014 and ended in January 2015. It contains information presented by numerous stakeholders. Each recommendation is supported by input from experts whose testimony is included in Addendum #3.

The Senate Commission offers these recommendations with full confidence that they will lead to more robust discussions of legislative and regulatory options.

Sincerely,

Joshua B. Miller
Senator
Co-Chair

Louis P. DiPalma
Senator
Co-Chair

Introduction

The United States spends more on health care than any other developed nation. The state of Rhode Island, our residents, our insurers, our providers, and our businesses are not immune from the impact of the continuing growth in health care spending. The Senate Commission on the Impact of Health Plan Patient Liability Provisions on Access to HealthCare and Provider Financial Condition reviewed some of the effects of consumer-directed health plans and other insurance plan designs in Rhode Island that require significant consumer cost-sharing, including patient copayments and deductibles. In general, consumer-directed health plans and high deductible health plans strive (a) to make consumers more conscious of medical costs (lowering overall use and expense) and (b) to lower insurance premiums paid by employers (by sharing some of the cost of care with employees as they use the benefits).

As reflected in testimony before the commission over the course of its four meetings (October 29, 2014; November 19, 2014; December 3, 2014; January 14, 2015), having health insurance doesn't necessarily guarantee that a patient can afford all of the health care they need. The costs of deductibles and out-of-pocket expenses that consumers shoulder can be prohibitive. According to research supported by The Commonwealth Fund, an independent organization that tracks health care affordability:

- low-income adults are the most likely among those insured all year to spend large shares of their income on health care
- more than two in five adults say their deductible is difficult to afford, and adults with low and moderate incomes are more likely to report difficulties
- adults with high deductibles report delaying needed health care, actions that can lead to more expensive care in the future
- lower-income adults also report difficulty affording their copaymentsⁱ

Information from the Hospital Association of Rhode Island (HARI) underscores the seriousness of the situation in Rhode Island. In the Ocean State, many employees (63%) who receive health insurance from small employers (less than 50 employees) have deductibles greater than \$1,000. Most people who purchase insurance through HealthSource RI choose high deductible plans, with deductibles that can exceed \$2,000.ⁱⁱ

All Rhode Islanders need to understand the interplay among health care plan design, copayments, and deductibles, and policymakers must ensure that there continues to be

ⁱ Commonwealth Fund (2014). Too high a price: Out-of-pocket health care costs in the United States. Available online at <http://www.commonwealthfund.org/publications/issue-briefs/2014/nov/out-of-pocket-health-care-costs>.

ⁱⁱ Hospital Association of Rhode Island (2014). *Tracking trends*, December 2014, Available online at http://www.hari.org/uploads/2014_nov.pdf.

transparency in the process associated with balancing the needs of patients, insurers, and providers. To help support such transparency, this Senate Commission provides this account of its work, as well as a series of findings and recommendations.

Executive Summary

The Commission presents the following series of recommendations:

Issue #1—Affordability of Health Insurance

Provide consumers with information to compare the cost and quality of care and providers.

Provide consumers with education on selecting a health plan.

The RI Division of Elderly Affairs must be included in any effort to educate Medicare beneficiaries of the potential impact of the patient liability associated with the choice of plans.

Issue #2—Provider and Patient Tracking of Patient Liability

Insurers offering health plans with a deductible should provide up-to-date information to patients.

Insurers should develop a method for providers to be informed of patient liability status, and/or develop a swipe card for patients that can keep track of the balance due toward the deductible and/or could be loaded with the total amount of the patient's deductible to be used like a credit or debit card at the point of service.

The Office of the Health Insurance Commissioner (OHIC) should spearhead a review of alternative approaches to provider payment for patient cost-sharing, that use a health insurance trust fund model, health insurance escrow accounts, or other mechanisms to help patients meet their financial liability requirements.

Issue #3 -- Access to Care

Explore the opportunities for the Office of the Health Insurance Commissioner to propose model plan designs that balance the need for cost containment with the need to ensure that preventive and needed care is encouraged, not discouraged, by the cost-sharing requirements.

Issue #4 – Provider Financial Liability

The Office of the Health Insurance Commissioner should continue to work on the issue of patient liability through its Administrative Simplification or other work group.

Findings and Recommendations

Issue #1—Affordability of Health Insurance

Findings:

Health care has moved gradually away from comprehensive health benefits and towards other approaches, including efforts to change patient behavior through increased cost sharing and high deductible health plans. Cost-sharing makes insurance plans more “affordable” for business and individuals. New products on the market reportedly will require 25% of the cost of the premium through patient liability.

HealthSource RI reports that it counsels individuals who are purchasing through the exchange, using the federal ACA affordability standard tied to family income. ACA cost-sharing plans and assistance connecting to health savings accounts are available through HealthSource RI.

A note of caution was raised that some insurance coverage is better than none. With insurance, patients will receive care sooner and in more appropriate settings. Caution must be taken to balance high deductible plans with the desire to have as many people insured as possible, while maximizing cost containment.

In addition, the work of the Rhode Island Coordinated Health Planning Council, as described in Rhode Island General Law 23-81-4, includes a comprehensive review of mental health and substance abuse incidence rates, service use rates, capacity, and potentially high and rising spending. This information will prove valuable to documenting the costs and cost drivers associated with mental health services in the Ocean State.

Recommendations:

Provide consumers with information to compare the cost and quality of care and providers.

If patients are to become sophisticated shoppers for health care, insurers must provide the tools they need to control their costs while seeking necessary care. This will become complicated with the establishment of networks that may decrease premium costs while decreasing patient choice of provider. Caution should also be considered in offering too many options with only a one or two service difference; the result could instead become overwhelming to consumers and inadvertently discourage patient engagement. Consideration should be given to providing a separate, clearly identified source of information at each insurer to address specific questions related to behavioral health coverage.

Provide consumers with education on selecting a health plan.

Those professionals who are connecting consumers with insurance should educate and advise individuals based on their income and expected health care expenses.

Affordability needs to be defined to include all out-of-pocket expenses, as well as the cost of the premium. Such information should also be made clear to consumers prior to purchase or enrollment and continuously throughout the term of the coverage. During enrollment, clarity should also be provided regarding the benefits that are covered and the consumer's financial responsibility when receiving services. By making the information clear and available to consumers throughout the process, this will encourage consumer engagement in making informed health care decisions.

The Office of the Health Insurance Commissioner should spearhead a review of alternative approaches to provider payment for patient cost-sharing, that use a health insurance trust fund model, health insurance escrow accounts (i.e., HSAs, HRAs, etc.), or other mechanisms to help patients meet their financial liability requirements. This review should include an exploration of the impact on premiums of moving collection of co-pays away from the point of service and to some other arrangement.

The RI Division of Elderly Affairs must be included in any effort to educate Medicare beneficiaries of the potential impact of the patient liability associated with the choice of plans. Medicare supplemental products offer greater cost sharing options.

Issue #2—Provider and Patient Tracking of Patient Liability

Findings:

The commission heard testimony that co-payments (usually a set dollar amount due when a prescription is picked up or a medical visit occurs) are not a major problem, since patients and providers are more aware of that liability and the point of service collection procedure. However, patients who have high needs and frequent, necessary health care visits may be choosing to avoid or forego needed care due to their copayments. (See Issue #3)

Deductibles can be more confusing, since the patient and their providers are not well-informed as to when the deductible is met. For example, a patient with a health plan that has a \$1000 deductible must pay the first \$1000 in health care expenses before their insurance will pay any future costs incurred. In many instances, keeping track of how much was paid out-of-pocket by the patient is not easy.

Providers will often send a bill to the insurance company without knowledge that the patient is responsible for the bill (i.e., the patient has not yet met the deductible out-of-pocket requirement). The provider can then attempt to recover the cost of care from the patient. Collecting up-front payments from the patient often creates tension with the provider. An alternative payment mechanism that allows immediate reimbursements to providers, such as through a trust fund model, health insurance escrow accounts (HSAs, HRAs, etc.), or similar health savings account that has a refundable, reimbursable component, may be worth considering.

Recommendations:

Insurers offering health plans with a deductible should provide up-to-date information to patients.

Blue Cross Blue Shield of RI presented information to the commission regarding the ability for consumers to track their financial obligations and progress toward meeting their deductible requirement through their website. Other insurers are encouraged to develop similar tools to the benefit of better informed consumers.

Insurers should develop a method for providers to be informed of patient liability status, and/or develop a swipe card for patients that can keep track of the balance due toward the deductible and/or could be loaded with the total amount of the patient's deductible to be used like a credit or debit card at the point of service. Up-to-date, timely data from insurers will assist patients decision-making and allow providers to better understand a patient's financial liability in terms of deductibles, lessening tensions between patients and the providers who care for them.

The Office of the Health Insurance Commissioner should spearhead a review of alternative approaches to provider payment for patient cost-sharing, that may consist of methods such as expanding the continued use of health savings accounts and other consumer savings tools. Through the Office of the Health Insurance Commissioner's Administrative Simplification Taskforce, an analysis can take place of best practices for alternative ways consumers can save money towards unexpected bills.

The Office of the Health Insurance Commissioner will work with RI REACH to gather survey results from healthcare consumers on whether or not preventative or needed care is avoided, postponed, or refused due to out of pocket expenses. The Office of the Health Insurance Commissioner will submit a report to the General Assembly and the Governor that describes and analyzes the incidence of such consumer actions and proposes recommendations based on the survey results.

Issue #3 -- Access to Care

Findings:

Health insurance benefit plan design influences patient behavior, both positively and negatively. Consumer directed health plans often result in cost-conscious behavior among patients that help to reduce utilization, health care spending, and overall costs.

However, high or repeated costs associated with receiving care and medications may act as a deterrent, particularly for individuals who are living on limited or low incomes.

Patient liability associated with health benefit design should not prevent patients from receiving a full course of treatment and the needed medications that will improve their functioning and productivity. Care avoidance due to patients' cost-sharing obligations often leads to more severe or acute health issues, accompanied by higher costs that could have been prevented through receipt of the appropriate care. Behavioral health represents one of the most costly conditions in Rhode Island, the state with the highest rate of serious mental illness and any mental illness in the nation. Cost-sharing presents a unique challenge to balance appropriate utilization with the reduction of barriers to access to necessary care.

Recommendation:

Explore the opportunities for the Office of the Health Insurance Commissioner (OHIC) to propose model plan designs that balance the need for cost containment with the need to ensure that preventive and needed care is encouraged, not discouraged, by the cost-sharing requirements. OHIC will continue to focus on behavioral health care parity as required by R.I. Gen. Law § 42-14.5-3(o). Patients in need of care for chronic conditions should face similar co-payments (parity) for both physical and behavioral health care services.

Particular attention should be paid to consumer health needs in addition to financial considerations in the area of plan design. In exploring alternative plan design options, the following factors may be considered where evidence supports better health care outcomes and long-term savings:

- Parity in the amount and timing of co-payments for behavioral health and substance use disorder services. Co-payment amounts and frequency for primary care services should be the same as applied to behavioral health and substance use disorder services.
- Elimination or reduction of co-payments to services and/or treatments for two to three selected chronic conditions; such as diabetes management, heart conditions, and behavioral health care. Chronic conditions may be selected from the findings in the state's most recent Community Health Needs Assessment performed by hospitals as required by federal law.
- Work with public and private employers to explore options to increase the provision of health escrow accounts (i.e., HSA, HRA, etc.) with any plan designed to have a patient financial liability over a specified amount such as \$1,000 or \$5,000.
- Addresses multiple co-pays for multiple subspecialty visits within a single visit. The monthly cost sharing amount that Blue Cross Blue Shield of Rhode Island (BCBSRI) piloted in its HealthPath program may provide an initial working model. The HealthPath program involves a strategic relationship among BCBSRI, The Providence Center, Continuum Behavioral Health (a wholly owned subsidiary of The Providence Center), and Care New England, designed to provide BCBSRI members with comprehensive behavioral health services. The program offers amultidisciplinary team approach, including psychiatry, nursing, independently

licensed clinicians, case managers, peer support specialists, and substance abuse specialists who provide office, home, and community-based services based on the members' identified needs. The services are intended to assist members struggling with behavioral health conditions in reaching their highest level of functioning through a coordinated and individualized treatment approach.

- Inclusion of the 11 categories of ACA essential health benefits (without deductibles) in low cost health care plans across different insurers

Issue #4 – Provider Financial Liability

Findings:

The scope of the problem for health care providers was reported in 3 areas of concern:

- (a) not knowing the balance of a patient's deductible;
- (b) not knowing the rate of reimbursement from an insurer on which to base the % co-insurance to collect from the patient; and
- (c) uncollected patient liabilities.

In each setting and among different providers of care, the extent of these areas of concern varies. All providers, however, reported significant increases in uncollected patient bills associated with the increased enrollment in health plans with higher cost-sharing.

Another shared concern is the difficulty and high cost associated with collecting unpaid bills. However, smaller provider entities (a physician office versus a hospital or clinic) reported the most difficulty associated with collections and a greater financial impact of patients' unpaid bills.

Recommendations:

The Office of the Health Insurance Commissioner should continue to work on the issue of patient liability through its Administrative Simplification Task Force or other work group. Once the data are analyzed regarding the impact of patient cost-sharing on access to appropriate care and on provider financial health, OHIC should work with insurers to provide:

1. a means to ease collections and refunds for reconciliation (being addressed by OHIC through the implementation of Regulation 2, Section 11)
2. patient education about co-payments that may not apply to preventive care (being addressed by OHIC through the implementation of Regulation 2, Section 11)
3. cost-sharing for routine or chronic care that encourages needed services (being addressed by OHIC through the implementation of Regulation 2, Section 11)
4. standardization of the coordination of benefits form (being addressed by OHIC through the implementation of Regulation 2, Section 11)
5. cost-sharing parity between physical and behavioral health care (OHIC will be providing the general assembly with a report on mental health parity as required by R.I. Gen. Law § 42-14.5-3(o))

6. real-time patient liability balance information (OHIC's Administrative Simplification Task Force sees this recommendation as a long term goal it would like to work towards)
7. a predictable reimbursement basis for the application of co-insurance percentages (OHIC's Administrative Simplification Task Force sees this recommendation as a long term goal it would like to work towards)
8. co-insurance rates need to be monitored for their growth, with the intent to work towards payment reform (OHIC may be able to work with insurers to identify and track relevant existing data).
9. an ID card that provides balance information that can be swiped and updated at the point of service. (OHIC's Administrative Simplification Task Force sees this recommendation as a long term goal it would like to work towards)
10. a "payment plan" revolving fund that can be tapped to offset unpaid bills or a safety net for individuals who are not able to meet their co-pays and deductibles.(OHIC's Administrative Simplification Task Force sees this recommendation as a short term goal it would like to work towards); and
11. the means to implement the recommendations contained in this report.

Commission Meetings

October 29, 2014

Review of Legislation

Setting up dates for next meetings

November 19, 2014

Presentations by Providers or Provider Associations

Discussion

December 3, 2014

OHIC- Update on Administrative Simplification

HealthSource RI

Insurers

Discussion

January 14, 2015

Discussion of Findings and any Recommendations

Discussion

Addendum 1:
Resolution Establishing the Commission

2014 -- S 3133

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LC006017
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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

SENATE RESOLUTION

**CREATING A SPECIAL LEGISLATIVE COMMISSION TO STUDY THE IMPACT OF
HEALTH PLAN PATIENT LIABILITY PROVISIONS ON ACCESS TO HEALTHCARE AND
PROVIDER FINANCIAL CONDITION**

Introduced By: Senator Joshua Miller

Date Introduced: June 20, 2014

Referred To: Placed on Senate Calendar

WHEREAS, It is the intention of state and federal law to ensure that Rhode Islanders have reasonable access to healthcare facilitated by health insurance coverage; and

WHEREAS, Individuals, employers, and employees select insurance coverage based on the balance between the level of coverage, reflected in the patient liability for services, and the cost of coverage, reflected in the premiums; and

WHEREAS, The reduced premiums associated with high deductible health plans and those that include other significant patient liability provisions have driven a sharp increase in the membership of these plans nationally and in Rhode Island; and

WHEREAS, The likelihood of collecting significant patient financial obligations, in the form of deductibles and other similar patient obligations, by healthcare providers diminishes

sharply once the patient leaves the site of services; and

WHEREAS, The cost of healthcare provider time and resources required to bill and collect patient financial obligations significantly increases once the patient leaves the site of service; and

WHEREAS, Patient financial obligations can be of such a magnitude that it creates extreme personal financial hardship, hinders access to needed care, steers patients toward inappropriate places of service (such as hospital emergency departments) and in the event it is not paid, creates financial hardship on the part of the healthcare provider; and

WHEREAS, These provisions can cause unintended consequences that are in opposition to the objectives of access to coverage, availability of care, and the financial stability of healthcare providers; now, therefore be it

RESOLVED, That a special legislative commission be and the same hereby is created consisting of seventeen (17) members: two (2) of whom shall be a members of the Senate, one of whom shall serve as chairperson, to be appointed by the Senate President; one of whom shall be the Commissioner of the Rhode Island Office of Health Insurance Commissioner, or designee; one of whom shall be the President/CEO of Blue Cross and Blue Shield of Rhode Island, or designee; one of whom shall be President of United Healthcare of Rhode Island, or designee; one of whom shall be the CEO of Neighborhood Health Plan of Rhode Island, or designee; one of whom shall be the Executive Director of the Rhode Island Business Group on Health, or designee; one of whom shall be a health insurance broker, to be appointed by the Health Insurance Commissioner; one of whom shall be the President of the Drug and Alcohol Treatment Association, or designee; one of whom shall be the President of the Community Health Center Association, or designee; one of whom shall be the President of the Council of Community Mental Health Organizations, or designee; one of whom shall be the Executive Director of the Rhode Island Medical Society, or designee; one of whom shall be the President of the Rhode

Island Academy of Family Physicians, or designee; two (2) of whom shall be the Acting President of the Hospital Association of Rhode Island, or designee, plus an additional designated representative, to be appointed by the Acting President of the Hospital Association of Rhode Island; one of whom shall be a representative of a hospital in Rhode Island that is not a member of the Hospital Association of Rhode Island, to be appointed by the Senate President; and one of whom shall be a representative of state government with expertise in computer technology and information system compatibility, to be appointed by the Senate President.

The purpose of said commission shall be to make a comprehensive study and make recommendations regarding the impact of significant patient liability provisions within health plans (to include coinsurance and deductibles), and individuals' and employers' desire for choice in the cost of coverage resulting from different levels of patient liability and their relationship to a person's access to healthcare, health insurance, personal financial well-being and the financial condition of healthcare providers. In studying this issue, the commission is encouraged to:

- (1) Examine trends, current policies, and available data pertaining to the growth in membership in health insurance plans containing significant patient liability provisions;
- (2) Examine the impact upon the growth of coverage under the Affordable Care Act (ACA) of insurance plans with significant enrollee liability provisions and the coverage alternatives to such plans;
- (3) Identify the volume of healthcare services rendered to patients with such coverage provisions and how much of the patient liability is collected and remains uncollected, and the time frames for billing and collection;
- (4) Identify the barriers to access to necessary primary and specialty health care related to insurance coverage and potential financial barriers of patient liability provisions in coverage;
- (5) Examine the degree to which health insurers, payers and employers evaluate the ability of potential members to afford the designated cost share prior to providing a plan that

includes them, while similarly considering the impact of cost sharing on premiums, how that affordability of premiums improves access to health insurance and the degree to which coverage, even with cost sharing, is preferable to an individual or employee being uninsured;

(6) Survey the use of software applications that enable real-time determinations of a patient's deductible status and examine the feasibility of an application to be used by health care providers for utilization at the time care is provided; and

(7) Examine the implication and feasibility of policies and legislation that would: (i) Establish a baseline means test for affordability of significant patient financial obligations prior to their purchase, recognizing that coverage with that cost sharing is preferable to being uninsured; (ii) Educate Rhode Islanders about the availability of Medicaid or other state assistance, premium subsidies (advance premium tax credits) and cost sharing subsidies under the ACA; and (iii) Educate patients about their obligation to satisfy their financial liability to their healthcare provider.

Forthwith upon passage of this resolution, the members of the commission shall meet at the call of the President of the Senate and organize.

Vacancies in said commission shall be filled in the same manner as the original appointment.

The membership of said commission shall receive no compensation for their services.

All departments and agencies of the state shall furnish such advice and information, documentary and otherwise, to said commission and its agents as is deemed necessary or desirable by the commission to facilitate the purposes of this resolution.

The Joint Committee on Legislative Services is hereby authorized and directed to provide suitable quarters for said commission; and be it further

RESOLVED, That the Commission shall report its findings and recommendations to the Senate on or before February 3, 2015, and said commission shall expire on July 1, 2015.

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LC006017

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
SENATE RESOLUTION
CREATING A SPECIAL LEGISLATIVE COMMISSION TO STUDY THE IMPACT OF
HEALTH PLAN PATIENT LIABILITY PROVISIONS ON ACCESS TO HEALTHCARE AND
PROVIDER FINANCIAL CONDITION

This resolution would create a seventeen (17) member special legislative study commission whose purpose it would be to study the impact of health plan patient liability provisions on access to healthcare and provider financial condition, and who would report back to the Senate, on or before February 3, 2015, and whose life would expire on July 1, 2015.

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Addendum 2:

Hearing Notes

SENATE COMMISSION TO STUDY HEALTH PLAN PATIENT LIABILITY PROVISIONS ON ACCESS TO HEALTHCARE AND PROVIDER FINANCIAL CONDITION

November 19, 2014

The following is a synopsis of the Rhode Island Senate's Health Plan Patient Liability Provisions on Access to Healthcare and Provider Financial Condition Commission meeting held on Wednesday, November 19, 2014 in the State House's Senate Lounge.

Welcome

Chairman Miller called the meeting to order at 2:00 PM and welcomed everyone to the Commission hearing. Chairman Miller addressed the charge that was discussed at the organizational meeting. He also informed the members and guests regarding the people and organizations who would be presenting at the November and December meetings.

Presentation

Kathleen Hittner, MD, Commissioner, Office of Health Insurance Commissioner Dr. Hittner informed the members that 40% of physician practices in the state report experiencing difficulty collecting co-pays. The Office of Health Insurance Commissioner (OHIC) is currently collecting data and will update the members at the December 3rd meeting on its progress. The Commissioner identified administration simplification as a positive step forward with insurers and providers, including the current discussion on patient deductibles.

Presentation (available in report)

Michael Souza, Hospital Association of RI (HARI)

Mr. Souza explained the impact on hospitals from 2006 to 2014, with 5% of uncollected fees being from co-payments. The more complex issue is knowing the balance due for deductibles (41% of uncollected), and the fee associated with each visit on which the co-insurance is based (accounting for 54% of uncollected).

Hospitals collect 27% overall of patient financial liability, and the remainder is in accounts receivables or considered bad debt. The uncollected dollar amount increased 20% over 3 years.

Point of service process:

How does the insurer know that patients paid their deductible?

The deductible is applied to the claim that is filed first, even if the money was paid to another provider by the patient. This results in refunds and difficulty with patient paying at point of service in the future. Hospitals collections at point of service vary greatly due to resources and systems (computer systems).

Co-Insurance is based on what is allowable for each procedure or service. This is difficult to calculate at the time of service and can result in incorrect collections, sometimes tied to denied services. Co-payments are the easiest to collect but the smallest % of patient financial liability.

Patient Education:

9 in 10 Americans have difficulty understanding everyday health information.

Routine services generate a deductible bill.

A patient's inability to pay impacts their credit rating, assets, and bankruptcy.

Wish List to improve processes

1. Goal of Commission-
Drive care and manage employee costs
2. Affordability Standard based on Income
3. Types of services for patient liability- certain treatments only?
4. Who collects- is that best?
5. Who educates? Standardize?
6. Incorporate Administrative costs
Standardized coordination of Benefit form
7. Use of ID card- balance that updates can be scanned & swiped

Presentation

Steve Detoy, RI Medical Society

15 years of data and bad debt handout (available in report)

Mr. Detoy stated that there is care avoidance due to deductibles, which have gone up 65% in one year. The affordability issue cannot be quantified.

Senator Miller raised the concern that all of this hurts the state's ability to attract health care specialists.

Data suggest there is four times the increase in care avoidance in 1 year; patients are not following up with their treatment plans.

Presentation (available in report)

Marc Proto, Lifespan

As insurers battle rising costs with higher premiums, people with employer-based plans are finding that, though they have good coverage, high deductibles often represent cost-sharing that they can't afford.

- Kaiser/HRET (Health Research & Educational Trust) Survey of Employer-Sponsored Health Benefits (2006-2014)
 - More than half of employees of small companies now have a deductible greater than \$1,000
 - High-deductible plans are creating a growing coalition of underinsured families.

Observations of RI small group membership by deductible-

- In the last two years, we have seen a shift to \$1,500 deductibles, and we expect this trend to continue
- There is also a shift in the application of deductibles. In addition to inpatient admissions, deductibles are now applied to out-of-pocket maximums. Patients are subjected to deductibles and a compounding co-pay for certain services.

Unintended effect of benefit design-

The intent was:

- Achieve lower health care costs by making patients more cost-conscious, and
- Make insurance premiums more affordable for the uninsured

The hope was:

- Patients would be more likely to get a health risk assessment, seek generic drugs, and ask more questions of their physicians before seeking more expensive care

The reality is:

- High deductible plans have compromised the two basic purposes of health insurance: to reduce financial barriers to needed care and to protect against financial hardship

- Insured adults with health problems are also placed at potentially greater risk of having difficulty accessing care when they are covered by a higher deductible plan

Effect on Healthcare Costs-

The only achievement is cost shifting from the insurer, to the patient, to the provider, which is not solving the problem.

Key issues to address:

- There is a lack of consumer education and awareness
- Patients don't realize what plan/product they have and insurance cards often are not clearly differentiated
- Out-of-pocket expenses are agnostic to patient affordability and agnostic to chronic conditions and disabilities
- There is a lack of understanding of the system-wide financial and clinical benefit of these products and how success is defined and measured
- Need to address multiple co-pays for complex populations requiring multi-specialty visits

Presentation (available in report)

Craig Syata, Rhode Island Council of Community Mental Health Organizations, Inc (RICCMHO)

Uncollected co-pays and deductibles from health plan enrollees for behavioral health care services are significant and the trend is increasing, doubling for most providers from FY 2013 to 2014. First quarter figures suggest that they will at least double again for FY 2015. There is no other funding to offset these losses and they are therefore uncompensated care.

Access to Services and Impact to Clients:

- Behavioral Health Services, with the limited exception of screening and evaluation, are considered specialty services by health plans. That means higher co-pays; the lowest we could identify was \$45. It also means that for coverage that includes deductibles, the deductible must be met before insurance payments start.
- Many or most mental health illnesses are chronic disease conditions. They typically require a higher frequency of treatment visits than other illnesses or diseases, sometimes multiple occurrences monthly. The high co-pays along with having to meet any deductibles effectively means that private insurance clients with limited or modest means have no coverage for behavioral health services because they can't afford the out of pocket expenses.
- Providers either end up with uncompensated care or clients cut back or stop seeking services. Both occur.

Health Care System Impact:

- Clients who avoid services or reduce the frequency of care and therefore do not follow treatment plans are at risk for hospitalizations, deterioration of their health status, and involvement with the corrections system- all higher cost consequences.
- Non-covered services, for example case management and medication monitoring, further puts clients at risk for the same consequences. Many behavioral drugs have unwelcome side effects and medication compliance is an issue.

BCBS indicated that the first dollar coverage equals 30% higher cost of premium.

They recommend a different payment model -- reimbursing differently will reduce the issue, but introduce a disconnect between plan design and payment models.

David Spencer of Drug and Alcohol Treatment Association

Will submit written comments, and states that there is an impact on avoided care for those with behavioral health care needs.

SENATE COMMISSION TO STUDY HEALTH PLAN PATIENT LIABILITY PROVISIONS ON ACCESS TO HEALTHCARE AND PROVIDER FINANCIAL CONDITION

December 3, 2014

The following is a synopsis of the Rhode Island Senate's Health Plan Patient Liability Provisions on Access to Healthcare and Provider Financial Condition Commission hearing held on Wednesday, December 3, 2014 in the State House's Senate Lounge.

Welcome

Chairman Miller called the meeting to order at 2:10 PM and welcomed everyone to the Commission hearing. Chairman Miller addressed the issues that were to be discussed at the prior meeting and informed the members and guests of the people and organizations who would be presenting today.

OHIC is presently collecting data; it is recommended that OHIC present its final report to the Senate Committee on Health and Human Services upon completion.

Presentation (available in report)

Christine Ferguson, HealthSource RI

- National research shows an impact of cost-sharing on care
- Need to balance affordability with how we choose to get care.
 - Contained vs. integrated networks
 - Full choice options
- Health Source RI does not collect patient copayments or deductibles

A way to fix the system is through consumer understanding, support, and transparency of choices on how individuals use care.

The Exchange Call Center assists with:

- Plan comparisons
- Individual plans and cost-sharing, we will have new data from Exchange
- Average time of calls is 30 minutes now, with time spent on counseling regarding choices, deductibles, and networks. 2015 promises to bring more than double the number of calls and walk-ins

From HealthSourceRI's power point slides (available in Report)

- 3% - 6.5% have Health Savings Accounts (HSAs)
- Federal Guideline: \$1300 individual deductible and \$5500 family deductible

- Rhode Island is in the middle of states offering deductible plans
- Cost sharing reduction plans are available for individuals with under 250% family poverty level, to ease impact and reduce cost-sharing
- Try to connect with HSAs on the Exchange---- 20% of Exchange shoppers left, mostly due to unable to pay (or new job). In 2015 almost 40% changed carrier; others are changing plans within same carrier.
- Are we going to allow choices that trade off financial costs and access to care?
- Important to provide consumers with upfront information to decide on costs and benefits.

Question posed to Ms. Ferguson:
What do you see as a remedy?

Response

- Access to care with best outcomes
- May be paying for provider choice that consumers do not need or use
- Education is required on integrated networks and Exchange staff to support consumers choices to reduce costs

Presentation (available in report)

Brenda Whittle, Neighborhood Health Plan of RI

In 2014 our enrollment is currently under 800. NHPRI is a partner with the state's health insurance exchange, Healthsource RI, in the effort to provide high quality health insurance at an affordable price to RI residents. We offer plans in both the small group and individual markets.

Health care is expensive and often presents financial hardship to people who experience severe injury or illness. Health literacy is a challenge, with 80 million committed to empowering and educating our members on the meaning of the cost-sharing provision of the plans we offer. The member materials and outreach efforts explain what it means to have a deductible, co-pay and co-insurance.

NHPRI is offering a new individual plan on the Exchange with no deductible and co-insurance requirements.

Presentation

Desmond Hussey, United Health Care

- Rhode Island is not an outlier in deductibles
- Consumers on the Exchange focus on "Silver Plans" due to the tax subsidy attached to this level of coverage.
- Federal law determines that there is a \$3,000 deductible with a maximum out-of-pocket total.

Perhaps should focus initially on doctors getting paid rather than on hospital payments due to the fact that hospitals get 80% paid back.

Suggestion:

Groups of employers with “1-100” employees could offer more than one plan, allowing employee choice to go with high or low deductible.

Questions & Discussion:

- Is there a way to smooth out deductibles over the course of a year and over providers?
- Is there a way to ensure a revolving fund for insurers to contribute to, to iron out “payment plan?”

Presentation (available in report)

Monica Nerona

Blue Cross Blue Shield of RI

- 50% of consumers on the Exchange are in cost-sharing plans
- BCBSRI provides provider education on how to collect at point of service (swipe card)
- New products on market require 25% of cost of premiums from patients
- Slides (in the report) show the BCBSRI web-based consumer education tools that allow information and tracking of consumer liability
- BCBSRI has begun a pilot program with the Providence Center and Care New England to address cost-sharing and care provision.

Addendum 3:

**Meeting Agendas,
Presentations, and Handouts**

**SPECIAL COMMISSION TO STUDY HEALTH
PLAN PATIENT LIABILITY PROVISIONS ON
ACCESS TO HEALTHCARE AND PROVIDER
FINANCIAL CONDITION**

NOTICE OF MEETING

DATE: Wednesday, October 29, 2014

TIME: 2:00 P.M.

PLACE: Senate Lounge- State House

Agenda:

- 1- Welcome
- 2- Review of the charge to the Commission
- 3- Setting up dates for next meeting

**SPECIAL COMMISSION TO STUDY HEALTH
PLAN PATIENT LIABILITY PROVISIONS ON
ACCESS TO HEALTHCARE AND PROVIDER
FINANCIAL CONDITION**

NOTICE OF MEETING

DATE: Wednesday, November 19th, 2014

TIME: 2:00 P.M.

PLACE: Senate Lounge- State House

Agenda:

1-Welcome

2- Presentations by Providers or Provider Associations

3- Discussion

**SPECIAL COMMISSION TO STUDY HEALTH
PLAN PATIENT LIABILITY PROVISIONS ON
ACCESS TO HEALTHCARE AND PROVIDER
FINANCIAL CONDITION**

NOTICE OF MEETING

DATE: Wednesday, December 3, 2014

TIME: 2:00 P.M.

PLACE: Senate Lounge- State House

Agenda:

1- Welcome

2- Presentations: OHIC- Update on Administrative Simplification
HealthSource RI
Insurers

3- Discussion

**SPECIAL COMMISSION TO STUDY HEALTH
PLAN PATIENT LIABILITY PROVISIONS ON
ACCESS TO HEALTHCARE AND PROVIDER
FINANCIAL CONDITION**

NOTICE OF MEETING

DATE: Wednesday, January 14, 2015

TIME: 2:00 P.M.

PLACE: Senate Lounge- State House

Agenda:

- 1- Welcome
- 2- Open Commission discussion of Proposed Recommendations
- 3- Next steps