

VIA E-MAIL

October 26, 2016

Emily Maranjian
Legal Counsel
Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920

RE: Proposed Amendments to Regulation 2

Dear Ms. Maranjian:

Blue Cross & Blue Shield of Rhode Island (“BCBSRI”) appreciates the opportunity to provide comments to the Office of the Health Insurance Commissioner (“OHIC”) regarding proposed revisions to OHIC Regulation 2. BCBSRI welcomes this opportunity to collaborate with OHIC to support and promote the adoption of delivery system transformation.

BCBSRI supports many of the policy objectives that the Commissioner is trying to achieve through the proposed amendments to the regulation. We have been an avid supporter of primary care, patient centered medical home programs, quality based hospital payments, and establishing systems of care, all with the goal of ensuring access to high quality and affordable healthcare for Rhode Islanders. We hope the Commissioner would agree that BCBSRI has been a leader in the state for transforming healthcare to achieve the triple aim of reducing costs, improving outcomes and improving quality.

Despite our unequivocal support for and commitment to these goals, we have several concerns with the proposed modifications to Regulation 2.

An overarching concern is that the regulation continues to hold carriers solely responsible through the rate review process and through their contracting with providers for affordability and payment reform. We accept our role and responsibility in driving these efforts; however, we argue that the rate review process is not the vehicle through which to set healthcare policy. We urge the Commissioner to propose new options – whether in regulation, through the Governor’s health leaders group, or in legislation – to expand responsibility and accountability for payment reform to all stakeholders. Without such accountability across stakeholders, we cannot achieve the triple aim.

With that background, we offer the following detailed comments.

Affordability Standards (Section 10)

Quality Measures (Section 10(d)(3)):

The regulation adopts standards for quality measures generally consistent with those set forth in the 2017 Rate Approval Conditions imposed on carriers as well as the accompanying OHIC clarification memorandum (“clarification memo”) dated July 25, 2016. We note that a number of these measures must be evaluated on an annual (calendar year) basis and that carriers and providers must be provided some

flexibility to contract accordingly. Additionally, new measures may require administrative effort on behalf of both a carrier and a provider.

BCBSRI recommends that the supporting documentation of Aligned Measure Sets published on the OHIC website should include: Measure name; Measure ID (NQF, PQRS, MIPS number, etc.); Measure Steward; Measure Specifications (unless NCQA or other proprietary entity); Measure Value Sets (unless NCQA or other proprietary entity); Approval Date; Implementation Date; and Annual Review Date.

We request that OHIC include language from the “Regarding Performance Measurement” section of the clarification memo that provides discretion to set minimum sample sizes for measures, including core measures, to ensure valid measurements. This section of the clarification memo permits the carrier to elect not to include any measure, including those deemed core, that does not meet a minimum sample size. Without this change, section (C)(i) appears in conflict with the clarification memo in that the regulation requires that contracts “shall include all” measures designated as core.

We recommend amending the proposed regulation as to when any modified or new Measure Sets are to be adopted into contracts. While each contract may have its own effective date, because measures generally should be evaluated on a calendar year basis, we suggest adding language to subsection (F) which would provide that new or modified Measure Sets be effective on January 1st of the calendar year that is at least 6 months following the date the measure is adopted.

We read section 10(e)(1) as applicable to Measure Alignment, permitting a carrier to seek a waiver or modification of one or more of the measures.

Hospital Contracts (Section 10(d)(4)):

We do not support the changes to hospital rates set forth in Section 10(d)(4)(E) that increases the hospital rate cap from the 2016 level of CPI Urban (CPI-U) +0.75% to CPI-U +1%. As the Commissioner is well aware, the key driver for affordability of health insurance premiums is the cost of healthcare. The limitation on hospital increases has served as an important tool during contract negotiations to keep costs at a reasonable level and transition toward quality based payments. With that in mind, rate filings for 2017 assumed the reduction required in Regulation 2 which was assumed to be CPI-U +0.5% for 2017. To impose this regulation after filings have been submitted and approved results in inadequate rates and a potentially significant loss to carriers, perhaps necessitating rate increases for employers and consumers.

Furthermore, the increase in hospital rates is at odds with other drivers of payment reform. The increase provides no incentive to hospitals to adopt alternative payment methodologies – indeed, it serves to encourage hospitals to work at odds to those efforts since staying in the current payment model could result in automatic increases. While carriers can, and will, continue to negotiate hospital rates aggressively and always had the ability to negotiate below the cap, without the support of Regulation the ability of any carrier to hold this line will be difficult.

If necessary to modify the rate cap at this point in time, we ask that the Commissioner freeze the cap at the projected 2017 level of CPI-U plus 0.50%. To revert to CPI-U +1% is not in the best interest of consumers and may affect solvency of carriers.

The regulation retains obligations for carriers to verify the operational and financial capacity and resources of a provider organization seeking to enter in to a risk sharing contract. (Section 10(d)(1)(D)) It

imposes on carriers a significant burden, using a false assumption of existing operating procedures in rating manuals, that carriers have the expertise or access to the necessary information to verify such capacity. Carriers also lack visibility into the total financial obligation of a provider organization across multiple-payers. We ask that this Section be deleted in its entirety.

Committee Work (Section 10(c) and (d)(2)):

As the Commissioner continues the work of the Alternative Payment Methodologies and Care Transformation Committees described in the regulation, it is imperative that further consideration and attention be given to the role of specialists in the overall cost and quality of care delivered to Rhode Islanders. We encourage the Commissioner to consider additional caps on reimbursement across the spectrum of providers and to adopt quality measures applicable to specialty providers in order to achieve total cost reductions.

Administrative Simplification Standards (Section 11)

The Administrative Simplification Task Force has provided carriers and providers with a valuable opportunity to build relationships, identify concerns, and resolve issues. We are committed to on-going efforts to address administrative complexity through our work directly with providers. We support the changes to the task force and, specifically, that requests be substantiated before they are considered. We suggest further modifications to reflect the discretionary nature of the task force going forward. Specifically, consistent with the revised nature of the task force, consider deleting the last sentence in section (a)(1): "The Chair and Co-Chairs of the Task Force shall be selected annually by its members." In addition, remove the following language in Section 11(a)(2): "The Task Force will meet during September, October and November to make its recommendations to the Commissioner for resolving issues identified in the work plan no later than December 31 of each year." Consistent with the revised nature of the task force, consider deleting the last sentence in section (a)(1): "The Chair and Co-Chairs of the Task Force shall be selected annually by its members."

We appreciate this opportunity to comment on the proposed revisions to Regulation 2. As always, we stand ready to answer any questions you may have regarding these comments. Please do not hesitate to contact me and I will be happy to coordinate such a conversation with the appropriate members of our team.

Sincerely,



Monica A. Neronha
Vice President, Legal Services

cc: Michele Lederberg
Mark Waggoner
Augustine Manocchia, M.D.

October 19, 2016

Dr. Kathleen C. Hittner
State of Rhode Island
Office of the Health Insurance Commissioner
1151 Pontiac Avenue
Building 69-1
Cranston, RI 02920

Dear Dr. Hittner:

Re: Comment letter regarding rate cap regulation

This letter is being sent to you on behalf of Women & Infants Hospital of Rhode Island, Memorial Hospital, Butler Hospital, and Kent Hospital, known collectively as the Care New England Health System (CNE). We appreciate the opportunity to offer comments in support of the changes to the current Office of the Health Insurance Commissioner (OHIC) regulation proposed by the Hospital Association of Rhode Island (HARI).

As you are aware, the 2016 OHIC maximum allowed rate increase was 2.65 percent with half of the increase tied to earnable quality measures on commercial lines of business. Also in 2016, the government enacted a 2.5-percent reduction in Medicaid rates. The financial impact of this was too significant for CNE to absorb and it created a number of organizational challenges.

During this period of time, CNE faced many financial difficulties while attempting to balance significant rate reductions in Medicaid and low commercial rate increases combined with steadily increasing costs of medical care. Exacerbating the situation were increased bad debt write-offs due to increasing unpaid patient liabilities. CNE faced these challenges head on, went to great lengths to reduce costs and adopted numerous operational efficiencies. Despite all the steps taken, a reduction in workforce could not be avoided. As we look forward to 2017, we have based our budget on the current OHIC legislation and we find the financial challenges to be consistent with years past.

The regulation modification proposed by HARI will continue the cap at CPI less food and energy +1 percent, .5 percent greater than the current regulation. This is important as decreasing the cap year after year is not sustainable, and will result in a loss of \$8,000,000.00 over the next three years. The proposed regulation would also allow the 50 percent dedicated to quality to be added to the base rate, which will provide some relief with the financial challenges that we face.

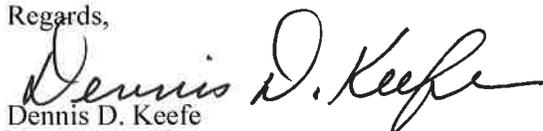
With regard to quality measures, CNE continues to be supportive of the use of quality measures applied consistently across all payers. This will allow an improved focus on measures that positively impact the quality of health care.

CNE also agrees that the Administrative Simplification Taskforce should be required to meet annually and the direction taken by the taskforce should be set by gathering information from members.

Finally, CNE is committed to participating in the goal of reducing the overall care cost of health care in the State of Rhode Island, but we must have infrastructure and resources to invest in our workforce and facilities.

Thank you again for the opportunity to provide these comments in support of the proposed changes.

Regards,



Dennis D. Keefe
President and CEO



CharterCARE
HEALTH PARTNERS

October 26, 2016

Kathleen C. Hittner, MD
Health Insurance Commissioner
Office of the Health Insurance Commissioner
State of Rhode Island
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920

Re: CharterCARE Health Partners' comments on proposed Regulation 2

Dear Dr. Hittner:

On behalf of CharterCARE Health Partners ("CCHP"), we appreciate the opportunity to provide comments on OHIC Regulation 2 to address the Hospital Rate Cap. CCHP is supportive of the proposed amendments regarding the rate cap and CPI adjustments. Hospitals in Rhode Island, including CCHP, continue to operate in a challenging economic environment with, among other issues, reductions in Medicare and Medicaid payments and historically low rates from the commercial payers with limited annual adjustments.

CCHP is a leader in Rhode Island on health care delivery and payment system reform, using its Coordinated Regional Care model to deliver healthcare in Rhode Island in line with the Triple-Aim principles. These revisions to Regulation 2 are an initial step in investing in the delivery system and payment reform needed in Rhode Island.

Other issues addressed in the proposed regulation are quality measures and the Administrative Simplification Taskforce. CCHP, like HARI, is supportive of consistency in the use of quality measures, to reduce the administrative burden placed on providers by the unaligned use of quality measures across payers, and to improve the quality of health care by channeling clinical focus on core areas of health care delivery. CCHP also believes the Administrative Simplification Taskforce should be required to meet annually (unlike the proposed regulation at the discretion of the commissioner) and we agree with gathering input from members to set the direction of the taskforce.

Sincerely,

John J. Holiver
Chief Executive Officer

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- | | | |
|----------------------------------|-------------------------------------|---------------------------------|
| • OUR LADY OF FATIMA HOSPITAL | • ROGER WILLIAMS MEDICAL CENTER | • ELMHURST EXTENDED CARE |
| • ST. JOSEPH HEALTH CENTER | • ROGER WILLIAMS CANCER CENTER | • CHARTERCARE HOME HEALTH |
| • CHARTERCARE MEDICAL ASSOCIATES | • SOUTHERN NE REHABILITATION CENTER | • PROSPECT PROVIDER GROUP OF RI |



Michael R. Souza
President

October 19, 2016

Kathleen C. Hittner, MD
Health Insurance Commissioner
Office of the Health Insurance Commissioner
State of Rhode Island
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920

Re: Stakeholder feedback on Regulation 2

Dear Dr. Hittner:

The Hospital Association of Rhode Island and its members appreciate the opportunity to provide comments related to OHIC Regulation 2, Section 10 (d) (3). Hospitals are transforming health care in many ways at their facilities and through the exploration of different contractual arrangements with payers. However, due to a decreasing trend in hospital utilization and reductions in payments from governmental payers, the bleak financial situation of hospitals will result in the lack for needed investments in the health care system.

This proposed regulation takes an initial step by the State of Rhode Island to invest in the health care system and ensure a healthy economy. Since the regulation was created in 2010, it has used the following matrixes to cap insurance premium rates as an effort to decrease medical expenditures:

- 2011-2012: CMS Price index + at least 2% for quality
- 2013-2014: CMS Price index + 1% and 50% of increase dedicated to quality
- 2015: CPI-U (less food and energy) + 1% and 50% of increase dedicated to quality
- 2016: CPI-U (less food and energy) + .75% and 50% of increase dedicated to quality

Currently, hospitals are able to receive up to 2.65%, with 50% dedicated to agreed upon quality initiatives. The quality payment is a separate and distinct payment, not put into the base. This amount based on the current regulation would have been reduced by .25% for the next three years. The maximum amount applied to the base is only 1.3%, which leaves facilities very little room to offset any operational expense increases.

The overall margin for hospitals in our state is negative with the majority losing money. Hospitals have experienced governmental payment reductions at the same time as these very minimal increases from commercial payers. Medicaid recently reduced payments to hospitals by 2.5% and Medicare has reduced payments to hospitals by 3.1%. Lastly, the bad debt due to patient liability is increasing dramatically and exceeding increases provided.



Michael R. Souza
President

The Wakely Consulting Group produced a report on medical cost trends in Rhode Island from 2011 to 2013 and found that hospitals were not a driver of medical expense increasing, nor out of line with other New England states. However, pharmaceutical expenses were shown to be driving the increase in medical expense. Pharmaceutical expenses were also a major driver in the most recently approved health insurance premiums. Blue Cross & Blue Shield of Rhode Island recently stated the decrease in inpatient utilization, not price, has been the leading factor in their losses.

There is a need to align future medical expense targets at a similar amount for all providers to ensure affordability and economic growth. Previously, there have been discussions focused on a statewide health care spending target of 3.5%, this is substantially different than the current and proposed cap on hospitals. This proposed regulation takes an initial step to ensure we are investing in our delivery system.

The proposed regulation will continue to cap hospitals at CPI+1%, which is .5% greater than the current regulation. Two important aspects of the proposed regulation are: 1) it will maintain the hospital rate cap at the same amount, rather than decreasing each year as the current regulation, 2) the 50% dedicated to quality is allowed to be put into the base. While the five-year impact analysis showed an improvement of approximately \$130 million, this assumes utilization is flat, the maximum rate is negotiated with the insurer, and all of the quality initiatives are achieved. \$130 million may appear significant in relationship to premium increases, but this increase is on \$5.5 billion of commercial payments to all providers over a five-year period.

The other two items addressed in the proposed regulation are quality measures and the Administrative Simplification Taskforce. We are supportive of consistency in the use of quality measures, to reduce the administrative burden placed on providers by the unaligned use of quality measures across payers, and to improve the quality of health care by channeling clinical focus on core areas of health care delivery. We believe the Administrative Simplification Taskforce should be required to meet annually (unlike the proposed regulation at the discretion of the commissioner) and we agree with gathering input from members to set the direction of the taskforce.

HARI and its members are eager to continue to work with OHIC to transform health care, but need to ensure we are aligning initiatives, investing in our delivery system, and addressing all areas impacting medical expense trend. If we want to achieve true delivery system reform, job growth and maintain the economic impact of hospitals, then we must invest in hospitals. Hospitals need the infrastructure to transform the delivery and payment system built around collaboration and innovation.

Sincerely,

A handwritten signature in black ink, appearing to read "MS", is written over a light blue horizontal line.

Michael Souza
President

TRACKING TRENDS

In 2010, the Office of the Health Insurance Commissioner issued a set of regulatory standards for commercial insurers, known collectively as the affordability standards. The commissioner recently released regulations to amend the rate cap following concerns from hospitals.

Rate Cap

Commercial/private insurance reimbursement rates are set through private negotiations between the insurer and provider. These negotiations have been stifled in recent years by a hospital rate cap introduced by the Office of the Health Insurance Commissioner. This cap has limited hospitals' ability to recoup shortfalls from caring for Medicare, Medicaid and charity care patients. The inability to recover these losses leaves hospitals without the funds needed to invest in their workforce, technology and efforts to transform the health care system.

The hospital rate cap regulation was created in 2010 and has had the following impact on hospitals in Rhode Island:

- 2011-2012: CMS Price index + at least 2% for quality
- 2013-2014: CMS Price index + 1% and 50% of increase dedicated to quality
- 2015: CPI-U (less food and energy) + 1% and 50% of increase dedicated to quality
- 2016 – CPI-U (less food and energy) + 0.75% and 50% of increase dedicated to quality – Currently 2.65%
- Decreased annually by 0.25% each year until at CPI-U with no inflator.

The overall margin in Rhode Island is negative with the majority of hospitals losing money. Hospitals in Rhode Island have experienced governmental payment reductions at the same time as these very minimal increases from commercial payers.

| \$200 Million Hospital | | | | |
|-------------------------------|------------------|---------------------------|------------------------------------|------------------------------------|
| Payer | Payer Mix | Annual Net Revenue | Expected FY 2016 increase % | Expected FY 2016 increase % |
| Medicare | 40% | \$80,000,000 | -3.1% | -\$2,480,000 |
| Medicaid | 25% | \$50,000,000 | -2.5% | -\$1,250,000 |
| Commercial | 35% | \$70,000,000 | 2.9% | \$2,030,000 |
| Total | 100% | \$200,000,000 | -0.9% | -\$1,700,000 |

**Note: The 2.9% increase for commercial assumes hospitals are able to obtain the maximum cap and achieve all of the 50% dedicated to quality.*

The example above shows the impact of the rate cap issued by OHIC. Without the ability to effectively negotiate contracts with insurers, hospitals are unable to recoup shortfalls from Medicare and Medicaid. Therefore, as the cost of providing services is increasing due to the rising cost of supplies and drugs, hospitals are paid less each year for the care they are providing to Rhode Islanders. This leaves our hospitals with an unsustainable negative margin and no funds for employee salary and benefit increases, investments in technology and infrastructure or system reforms.



Medical Expense Trend

A recent report by Wakely Consulting Group noted that hospitals were not the driver of medical expenses increasing, nor were Rhode Islanders' medical expenses out of line with other New England states. However, pharmaceutical costs were shown to be leading the medical expense trend and was a major driver in the health insurance premiums recently approved by OHIC.

In addition, Blue Cross & Blue Shield of Rhode Island recently stated that utilization, not price, has been the issue resulting in the insurer's financial losses.

| State | Normalized Allowed PMPY | | | Normalized PMPY Trend | | |
|---------------|-------------------------|----------------|----------------|-----------------------|--------------|-------------|
| | 2011 | 2012 | 2013 | 2012 | 2013 | Avg |
| Connecticut | \$5,097 | \$5,485 | \$5,669 | 7.6% | 3.3% | 5.5% |
| Massachusetts | \$4,781 | \$4,944 | \$5,053 | 3.4% | 2.2% | 2.8% |
| Rhode Island | \$4,781 | \$4,888 | \$4,837 | 2.2% | -1.0% | 0.6% |
| New England | \$4,956 | \$5,193 | \$5,343 | 4.8% | 2.9% | 3.8% |

The table above identifies Rhode Island as having the lowest medical Per Member Per Year (PMPY) expense trend in New England.

Proposed Regulation Impact

Hospitals are pleased OHIC has proposed regulations that begin to address our concerns about the hospital rate cap. The proposed regulation will continue the hospital rate cap at the same amount, rather than decreasing each year as prescribed in the current regulation. Additionally, the 50% dedicated to quality will be allowed to be put into the base, and will not be collected separately after achievement.

While the five-year impact analysis by OHIC showed an improvement of approximately \$130 million, this assumed utilization remains the same, the maximum rate is negotiated by the insurer and all of the quality initiatives are achieved. HARI believes the actual impact will be significantly less.

In addition, while any improvement is helpful to hospitals and their mission, \$130 million will have a very small impact on hospital margins. Hospitals receive more than \$5 billion in commercial reimbursements each year, and a \$130 million improvement over five years will impact hospital margins a fraction of a percent.

| Proposed Rule Impact | | | | | | |
|--------------------------|-------------|--------------|--------------|--------------|--------------|----------------------|
| Year | 2017 | 2018 | 2019 | 2020 | 2021 | Total (5 Years) |
| | 1 | 2 | 3 | 4 | 5 | |
| (-1%) Utilization | \$5,418,165 | \$13,826,574 | \$25,446,781 | \$37,596,818 | \$50,295,255 | \$132,583,592 |
| (0%) Utilization | \$5,471,421 | \$14,099,263 | \$26,202,431 | \$39,091,744 | \$52,806,287 | \$137,671,147 |
| (1%) Utilization | \$5,524,677 | \$14,374,615 | \$26,972,896 | \$40,630,815 | \$55,416,626 | \$142,919,629 |

Important Step

Approval of this regulation is an important first step in addressing the negative effect of the hospital rate cap. Hospitals must have the resources necessary to achieve delivery system reform, support job growth and improve infrastructure. We ask state leaders to support this, and other measures that assist hospitals in strengthening their financial solvency, so they may invest in our state.



Lifespan

Delivering health with care.

October 25, 2016

Dr. Kathleen C. Hittner
Health Insurance Commission
Office of the Health Insurance Commissioner
1511 Pontiac Ave. Bldg 69-1
Cranston, RI 02920

Timothy J. Babineau, MD
President and
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Professor of Surgery
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RE: Proposed Amendments to Regulation 2; the Affordability Standards

Dear Commissioner Hittner:

We write to provide comments on the Office of the Health Insurance Commissioner's (OHIC) proposed amendments to the Affordability Standards (Amended Regulation 2) subsection (10(d)(3)), Section 10(d)(4) and Section 11. As the state's largest healthcare system and primary safety net provider, we appreciate the opportunity to provide comment on the proposed amendments as we continue our efforts to transform the delivery of healthcare.

Lifespan supports the proposed regulations that will maintain the hospital cap at CPI+1% rather than it decreasing each year under the current regulation. In addition, Lifespan supports the proposed regulation that will allow the 50 percent dedicated to quality to be added to the base. We write favorably about these proposed changes because they recognize that the amendments to the Affordability Regulations in 2015 concerning the capping of rates at CPI+ a sliding percent decrease failed to take into account the impact on providers such as Lifespan. The consequences under the existing regulation were that premium increases continued while providers' reimbursements were capped. While Lifespan supports the current proposal, we still remain concerned about the 2015 final amendments to Regulation 2 that imposed caps on insurance premium rates in an effort to decrease medical expenditures. However, establishing an immutable hospital cap, at this time, will provide a level of certainty in future negotiations.

In addition to the proposed regulation, Lifespan proposes that OHIC's Amended Regulation 2 include an add-on to the CPI+1% of another one percent for Level I adult and pediatric trauma centers. Rhode Island Hospital's Trauma Center has been verified as Level I for over 20 years while Hasbro's has been since 2014. The value of trauma centers is unquestionable. Injuries are the leading cause of death for children and adults under 44. Victims of traumatic injury who obtain access to a Level I trauma center are 25 percent more likely to survive than those treated at a general hospital. Lack of adequate funding is a significant factor in many trauma center closures with 30 percent of trauma centers closing in a 15-year period nationally. Accordingly, Lifespan continues to support efforts for both the state and federal governments to recognize that trauma is the third most expensive medical condition at an annual

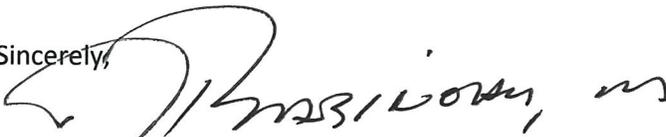
national cost of \$67.3 billion (behind only heart disease - \$90.9 billion – and cancer - \$71.4 billion). Maryland’s Health Services Cost Review Commission recognized the vital role that trauma centers provide in 2004 when it recommended, which was then adopted, reimbursements for standby costs. Ensuring that Rhode Island has and maintains a Level I adult and pediatric trauma center is critical to saving lives.

Moreover, hospitals continue to face state and federal cuts under Medicaid and Medicare while continually being required to innovate regarding such things as care transformation or alternative payment models. Importantly, even though the State continues to press for or regulate new initiatives, it fails to incentivize the extraordinary amount of work for both the process and functionality necessary within the health system. Accordingly, the inclusion of Lifespan’s proposed Level 1 adult and pediatric trauma center add-on will evidence recognition of not only the tremendous cost of activation, standby and transformation costs but also the importance of this life-saving service. This proposal is also consistent with Medicare OPPS reimbursements for critical care ED visits.

Lifespan also supports the proposed regulation seeking to align quality measures with the effort currently underway by the SIM Steering Committee under the SIM grant. The SIM subcommittee addressing quality measure alignment has been meeting for over a year and has been making substantial progress on identifying quality metrics. Even with no regulatory authority to act, the SIM is providing an invaluable function on quality metrics that eventually required OHIC’s regulatory adoption. Accordingly, this proposal will help reduce the variety of quality measures utilized by payors and thus simplify reporting by providers.

Finally, with regard to the proposal allowing the Administrative Task Force to meet at the discretion of the Health Insurance Commissioner, Lifespan supports a minimum of a biannual meeting. In our efforts to improve efficiencies and the delivery of care, a forum to discuss regulatory simplifications is crucial to both our efforts and those of the State.

Thank you again for the opportunity to comment on the proposed amendments to the regulations and as always we look forward to working with your department in the development of responsible health care policies.

Sincerely,


Timothy J. Babineau, MD
President and Chief Executive Officer

October 26, 2016

Kathleen C. Hittner, MD
Health Insurance Commissioner
State of Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920-4407

Dear Commissioner Hittner:

Neighborhood Health Plan of Rhode Island (Neighborhood) appreciates the opportunity to provide comments to the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) concerning the proposed amendments to OHIC Regulation 2 that were noticed on September 26, 2016. Neighborhood has significant concerns with these amendments and offers some suggested alternatives to Section 10(d)(4) titled "Hospital Contracts."

Specifically, Neighborhood is concerned about:

1. **Inconsistency with State Health Care Goals:** The proposed amendments are inconsistent with the recommendations of Governor Raimondo's Working Group for Health Care Innovation in that they do not further encourage alternative payment models and instead will result in a marginal increase in allowed hospital claims of approximately \$5.5 million in 2017 and approximately \$138 million in total by 2021. These figures are according to OHIC's own impact estimates provided at the Health Insurance Advisory Council meeting on September 20, 2016.
2. **Disruption of Rate Hearing Efficacy:** Since OHIC has already approved 2017 rates that were developed assuming that the existing hospital price inflation cap schedule would be in place, it is not actuarially sound for OHIC to make changes to the existing hospital price inflation cap schedule effective prior to 2018. If OHIC elects to proceed with making modifications effective in 2017, it could result in adverse financial consequences for commercial health insurance issuers.

For these reasons, Neighborhood strongly encourages OHIC to:

1. **Consider Halting or Delaying the Increase:** Neighborhood respectfully requests OHIC consider halting the increase to the hospital price inflation cap. If the increase must go forward, OHIC should delay the increase to be effective starting in 2018 if OHIC determines that modifications are otherwise necessary.
2. **Adopt a Value-Driven Strategy:** Consider a strategy that is consistent with the larger health care goals of Rhode Island. For example, requiring any increases to the hospital price inflation cap above the existing hospital price inflation cap schedule be in the form of quality incentive payments and not fee-for-service rate increases

Please contact me at (401) 459-6141 or pmarino@nhpri.org with any questions regarding these comments. Thank you for your consideration.

Sincerely,



Peter M. Marino
President and Chief Executive Officer