

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
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**CONCISE STATEMENT OF THE PRINCIPAL REASONS FOR AND AGAINST
THE ADOPTION OF THE AMENDMENTS TO OHIC REGULATION 2,
POWERS AND DUTIES OF THE OFFICE OF THE HEALTH INSURANCE
COMMISSIONER**

Introduction.

The Office of the Health Insurance Commissioner ("OHIC") hereby provides, in accordance with R.I. Gen. Laws § 42-35-3(a)(2), a concise statement of the principal reasons for and against these amendments to OHIC Regulation 2 ("Adopted Regulation").

The amendments were originally filed in proposed form with the Rhode Island Secretary of State on November 5, 2014 ("Proposed Amendments"). A public hearing on the Proposed Amendments was held on December 5, 2014. Written comments were received by OHIC. The comments of interested parties can be found at: <http://www.ohic.ri.gov/documents/Insurers/Regulations/Public%20Comments%20Reg%202/Written%20Comments%20Proposed%20%20Regulation%202.pdf>

The Adopted Regulation was adopted by the Commissioner on February 2, 2015, in accordance with R.I. Gen. Laws section 42-35-3. The Adopted Regulation is effective February 23, 2015.

This Statement provides: (A) a Summary of the Adopted Regulation, (B) an Explanation of the policy rationale for the Affordability Standards, which are included as part of the Adopted Regulation, and (C) Comments received by OHIC concerning the Proposed Amendments, and OHIC's responses to those comments.

A. A Summary of the Adopted Regulation.

The Adopted Regulation is intended to:

1. Reaffirm that progress towards affordable health insurance is central to the core statutory mission of OHIC, and is essential to promoting the public interests of individual residents, businesses, and public and private institutions in the state.
2. Revise and update the Affordability Standards established within the Adopted Regulation to reflect changes in Rhode Island's health care and health insurance system since prior versions of these regulations were adopted. These revisions and updates to the Affordability Standards include:
 - Clarifying and updating the obligations of Health Insurers to support the primary care delivery system, which is an essential building block for a reformed and affordable system.
 - Establishing the obligations of Health Insurers to support care transformation in the health delivery system, in collaboration with health care providers and other stakeholders, so that health care providers are

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capable of participating in Integrated Systems of Care designed to improve the quality and efficiency of the health care and health insurance system.

- Establishing targets for Health Insurers to enter into Population-Based Contracts, where reimbursement to health care providers is inclusive of the total, or near total cost of care for an identified population.
 - Establishing obligations for Health Insurers, in collaboration with health care providers and other stakeholders, to reduce fee-for-service as a payment methodology, and increase alternative payment methodologies that avoid the inflationary consequences of fee-for-service spending.
 - Maintaining and updating existing Health Insurer hospital contracting obligations, including limits on annual hospital rate increases.
 - Establishing Health Insurer obligations relating to annual budgets when contracting with Integrated Systems of Care.
3. Adopt standard procedures for the administration of health insurance claims, developed in cooperation with the Administrative Simplification Task Force¹, including standard procedures for retroactive terminations, coordination of benefits, appeals for “timely filing” denials and medical record management. These standard procedures are designed to make claims administration more efficient and effective for providers, consumers and Health Insurers.
 4. Adopt price disclosure requirements for Health Insurers, so that consumers can better understand the cost of health care services, and so that physicians can be more cost-effective when referring their patients to other providers and facilities.
 5. Establish reporting requirements for Health Insurers for the purpose of monitoring the implementation of and adherence to the Affordability Standards.

The remainder of the Adopted Regulation constitute changes to grammar and to form.

B. An Explanation of the Policy Rationale for the Affordability Standards.

Background & Context.

In 2008 the Office of the Health Insurance Commissioner, after consultation with the Health Insurance Advisory Council,² issued OHIC’s original Affordability Standards to promote affordable health insurance coverage. The Affordability Standards contained four key components: (i) investments in primary care infrastructure, based on studies that have shown that an adequate supply of primary care physicians can reduce health disparities across racial and socioeconomic groups, improve health outcomes and reduce costs; (ii) expansion of the adoption by primary care practices of the patient-centered medical home (“PCMH”) model, based on evidence indicating that a primary care “medical home” focused on improving care for people with chronic conditions can improve quality and lower costs significantly; (iii) standardize provider incentives to

¹ The Administrative Simplification Task Force is authorized by R.I. Gen. Laws § 42-14.5-3(h).

² The Health Insurance Advisory Committee (“HIAC”) is appointed by the Commissioner in accordance with R.I. Gen. Laws section 42-14.5-3(c).

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adopt Electronic Medical Records systems³; and (iv) a collaborative process to change how providers are paid, by reducing reliance on traditional, inefficient fee-for-service payment methodologies.⁴

The result of the payment reform collaborative effort was the establishment of required terms for hospital reimbursement contracts, attached as conditions to the Commissioner's approval of health insurance rates. The Hospital Contract Conditions required Health Insurer-Hospital reimbursement contracts to use unit of service payments that encourage efficient resource use, use the Medicare Inpatient Prospective Payment System rate increase index as a limit on hospital rate increases, implement quality incentives, promote administrative simplification and care coordination, and provide for public transparency in hospital contracting. Subsequent rate approval conditions made refinements to the Hospital Contract Conditions.⁵

In 2011, OHIC conducted an assessment of the Affordability Standards.⁶ The Assessment determined that the Affordability Standards were working in that Health Insurers and other stakeholders were participating in the reform initiatives, Health Insurers were complying with some but not all of the Standards, and it was too early to say whether the initiatives were successful in reducing costs and service disparities. The Affordability Standards were adopted as amendments to OHIC Regulation 2 in 2012.⁷

In 2013 and 2014 OHIC conducted a thorough review of the Affordability Standards, received the advice and recommendations of the Health Insurance Advisory Council, and solicited comments from stakeholders.⁸ The Adopted Regulation is the result of this assessment and these deliberations.

The Health Insurance Commissioner is adopting these amendments to Regulation 2 – Powers and Duties of the Office of the Health Insurance Commissioner – in order to continue to promote affordable care in Rhode Island through use of its regulatory powers to review and approve health insurance rates and rate factors proposed by Rhode Island's commercial Health Insurers.⁹

³ This element of the Affordability Standards has been superseded by similar incentive programs in the Affordable Care Act.

⁴ http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/6_Issue%20Brief.pdf

⁵ E.g. 2014 Hospital Contracting Conditions available at:

http://www.ohic.ri.gov/2014%20Rate%20Review%20Final%20Decision/3_Carrier%20Rate%20Approval%20Conditions%20Signed.pdf

⁶ http://www.ohic.ri.gov/documents/Insurers/Reports/Affordability%20Standards%20Assessment/3_2011%20Affordability%20Standards%20Assessment.pdf

⁷ http://www.ohic.ri.gov/documents/Insurers/Regulations/Regulation%202%20Final%2092812/1_Concise%20Summary%20of%20Adopted%20Regulation%202%20Effective%2092812.pdf

⁸ Assessment of the RI Office of the Health Insurance Commissioner's Affordability Standards. Final Report, 2014. Available at: <http://www.ohic.ri.gov/2013%20Affordability%20Standards%20Report.php>

⁹ R.I. Gen. Laws section 42-62-13(a). For additional legal analysis relating to the authority of the Commissioner to adopt Affordability Standards, see

http://www.ohic.ri.gov/documents/Insurers/Regulations/Regulation%202%20Final%2092812/1_Concise%20Summary%20of%20Adopted%20Regulation%202%20Effective%2092812.pdf

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Health insurance is an essential product demanded and financed by individuals, families, private employers, and governmental employers. Health insurance protects individuals and families from financial losses due to sickness and injury, enhances access to timely preventive and acute medical services, and supports the maintenance of healthy and productive lives. Therefore, consumers of health insurance have an interest in stable, predictable, affordable rates for high quality, cost efficient health insurance products. The State of Rhode Island has a strong interest in affordable health insurance as part of the effort to build a sound economy offering good employment opportunities to its residents. The affordability of the state's health care system directly affects the affordability of health insurance. On average, 87% of total health insurance premium is paid out as medical claims.¹⁰ With expected plan level medical trends in 2015 ranging from 5.4% to 6.4%, health care costs represent the key driver of increasing health insurance premiums.¹¹

Regulation 2 sets forth standards ("Affordability Standards") for Rhode Island's Health Insurers that advance policies and practices which improve the efficiency and affordability of Rhode Island's health care system. The Commissioner recognizes that Health Insurers can affect the affordability of their product offerings through provider contracting strategies, use of payment methodologies that promote value, and plan design, among other means. Collectively, the Affordability Standards allow the Office to fulfill two core components of its statutory directive:

- (1) Encourage policies and developments which improve the quality and efficiency of health care service delivery and outcomes; and
- (2) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.¹²

The Affordability Standards are founded on the following key principles:

- The Office can and should set standards to ensure collective action among Health Insurers to promote policies and developments which improve the quality and affordability of health care service delivery where unilateral action may be insufficient in scope or fail to materialize at all; and
- Regulatory standards can advance the public interest in affordable health care by specifying achievement targets related to efficiency-enhancing delivery system innovations and payment reforms. Achievement targets can influence the direction and pace of reform efforts.

Standard No. 1 - Primary Care Spend Obligation.

¹⁰ Based on insurer Medical Loss Ratio (MLR) reporting.

¹¹ Expected plan level medical trends reported in the 2014 annual rate filing for plans to be sold in 2015.

¹² R.I. Gen. Laws section 42-14.5.2

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The purpose of this Standard is to ensure sufficient financial support for primary care providers in Rhode Island, in order to achieve the fundamental goals of the Affordability Standards.

In 2008, OHIC conducted a study of high performing health care systems and their affiliated health plans – including Geisinger Health Plan, Intermountain Health Plan, and Group Health in Washington State – regarding their levels of primary care spend compared to the primary care spend level in Rhode Island. The data showed that Rhode Island, with an average of 5.9% primary care expenditures, was noticeably below the benchmark plans, which had a low of 7.1% (a Massachusetts HMO) and a high of 14.0% (Group Health of Washington State).¹³ Drawing on research indicating that a more robust primary care sector would both improve quality and reduce costs,¹⁴ and based on the benchmark data, OHIC established a requirement that each Health Insurer must increase the percentage of its total medical spend that is directed to primary care by 1% annually. At the end of 2014, primary care spend in Rhode Island is projected to be 10.6% of total medical spend, which is slightly above the 9.9% target. Since 2013 efforts to update the benchmarking study were not successful, OHIC decided that it was important to sustain the increases in primary care spending that had been achieved by setting a primary care spend target at a level slightly above the projected 2014 level and to seek grant funding for a rigorous benchmarking study of high performing systems. OHIC selected 10.7% as the level that must be maintained unless it is adjusted by the Commissioner after additional research.

Under the original Affordability Standards, Health Insurers were required to increase the percentage of total medical payments that are made to primary care clinicians by 1 percentage point per year and increase primary care funding directed to non-FFS activities by 5 percentage points per year¹⁵. In the 2014 assessment of how the Affordability Standards were being implemented, OHIC found that much of the non-fee-for-service expenses were directed to services, such as CurrentCare, that while beneficial to primary care providers, were not providing a direct benefit with regard to capacity building within primary care practices – a function considered essential for care transformation in health care. OHIC also found that the current level of total primary care spend (10.6%) was generally in line with the benchmarks identified in 2009. As a result of these findings, OHIC decided to focus the revised Affordability Standards on two goals: 1) retain the level of primary care spend made to date until more updated benchmarking data could be developed, and 2) promote direct support for primary care practice infrastructure and skill development necessary to support practice

¹³ M. Bailit and C. Koller. “Using Insurance Standards and Policy Levers to Build a High Performance Health System,” page 5. Issue Brief published by The Commonwealth Fund, November 2009.

¹⁴ S. Kravet, A. Shore, R. Miller et al., “Healthcare Utilization and the Proportion of Primary Care Physicians,” *American Journal of Medicine*, Fed. 2008 121(2): 142-48; K. Baicker and A. Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care,” *Health Affairs Web Exclusive Supplements*, Jan – June 2004 W4:184-97.

¹⁵ Under this requirement, the Health Insurers have increased total primary care spending from 6.3% of total medical spend in 2009 to 10.6% in 2014. Moreover, Health Insurers reported in 2014 that approximately 45% of primary care spend was directed to non-fee-for-service activities.

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transformation. To implement these goals, OHIC developed definitions for direct and indirect primary care expenses and set minimum funding standards for direct spending.

Standard No. 2 - Primary Care Practice Transformation.

The purpose of this Standard is to encourage transformation of Rhode Island primary care practices into PCMHs by setting contracting targets for Health Insurers and by creating and funding an annual Care Transformation Plan.

After assessing the effectiveness of the Affordability Standards in effect between 2009 and 2014, OHIC determined that continuing to promote PMCHs as one strategy for promoting affordability was warranted.¹⁶ OHIC has concluded that a robust primary care practice sector that is built on patient-centered medical homes is a critical component of a health care delivery system that supports affordable health care coverage. Promoting PCMH expansion is also key to Rhode Island's state-wide, multi-stakeholder health care innovation plan, the implementation of which is being funded by the Centers for Medicare and Medicaid Services ("CMS") under a recently awarded \$20 million grant.¹⁷ Supporting this finding is growing research evidence that suggests that PCMHs, if effectively designed and implemented, can produce improved population health and decreased per capita spending through transformed care delivery.¹⁸

It is also important to note that PCMH promotion in Rhode Island is important beyond the potential benefit of improved health and reduced costs for PCMH patients. A new health care delivery entity – called an Integrated System of Care – is starting to develop in Rhode Island. As defined in the regulations, an Integrated System of Care, also called an Accountable Care Organization ("ACO"), is "one or more business entities consisting of physicians, other clinicians, hospitals and/or other providers that together provide care and share accountability for the cost and quality of care for a population of patients, and that enters into a Population-Based Contract, such as a Shared Savings Contract or Risk Sharing Contract or Global Capitation Contract, with one or more Health Insurers to care for a defined group of patients." Health care policy experts consider the hallmark of successful Integrated Systems of Care to be a strong primary care system that delivers care using PCMH principles.¹⁹ Therefore, promoting PCMH transformation will help ensure that Rhode Island ACOs will be effective.

¹⁶ Assessment of the RI Office of the Health Insurance Commissioner's Affordability Standards. Final Report, 2014. Available at: <http://www.ohic.ri.gov/2013%20Affordability%20Standards%20Report.php>

¹⁷ See the US Department of Health and Human Services Press Release, dated December 16, 2014: www.hhs.gov/news/press/2014pres/12/20141216a.html

¹⁸ Nielson M at al. "The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-13" PCPCC, January 2014. ; Early Evidence on the Patient-Centered Medical Home. Prepared for the Agency for Healthcare Research and Quality by Mathematica Policy Research. February 2012; Thomas Bodenheimer and Rachel Berry-Millett. "Follow the Money — Controlling Expenditures by Improving Care for Patients Needing Costly Services" *N Engl J Med* 2009; 361:1521-1523 October 15, 2009.

¹⁹ Meyers D, Peikes D, Genevro J, Peterson G, Taylor EF, Lake T, Smith K, Grumbach K. "The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care." AHRQ Publication No. 11-M005-EF. Rockville, MD: Agency for Healthcare Research and Quality. December 2010.

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This Care Transformation Standard has three separate, but interrelated requirements that promote PCMH adoption. First, it requires that each Health Insurer take necessary actions such that by December 31, 2019, 80% of Rhode Island primary care practices that are contracted with Rhode Island insurers are functioning as Patient Centered Medical Homes. Rhode Island has a strong foundation of PCMHs upon which to build additional PCMH capacity. Currently, 41 practices are participating in the CSI-RI (now CTC-RI) initiative which is a multi-payer initiative, overseen by OHIC since 2009, that trains and provides incentives for primary care practices to become PCMHs. Blue Cross Blue Shield of Rhode Island (“BCBSRI”) has its own PCMH initiative. OHIC estimates that 45% of Rhode Island primary care practices are involved in PCMH transformation. The Standard, thus, requires Rhode Island Health Insurers Plans working with OHIC and Rhode Island primary care providers, to continue building on the transformation successes to date.

Second, the Standard requires that Health Insurers promote PCMH transformation by including both incentives and disincentives within their provider contracts for practices not participating in PCMH transformation initiatives. Examples of possible disincentives include lower reimbursement levels for providers that are not undergoing practice transformation, public reporting to members regarding practice transformation activities, or closing new member access to non-transforming practices. By requiring insurers to implement disincentives for practices that do not transform, OHIC is creating a real and tangible reason for practices currently not engaged in practice transformation to do so.²⁰ These measures will also mitigate against the negative consequences for the system as a whole if these providers do not engage in practice transformation. Only with a critical mass of primary care practices using PCMH practices and principles can the results of practice transformation benefit Rhode Island’s health care and health insurance system.

The use of disincentives works in tandem with the PCMH expansion targets. Specifically, in the course of assessing the existing Affordability Standards, OHIC held extensive discussion with Rhode Island insurers and with CTC-RI transformation staff, who consistently reported that all primary care practices interested in undertaking PCMH transformation were currently involved in a PCMH initiative. Those not participating were generally described as small, independent practices that did not have the interest in or appreciate the need to undertake transformation. The Commissioner is, therefore, using OHIC’s regulatory authority to create motivation for these practices to transform. By creating the 80% PCMH target for 2019, OHIC is providing time for practices to transform.

Third, to assist in PCMH transformation, the Commissioner will convene a Care Transformation Advisory Committee to develop an annual care transformation plan designed to achieve the 80% target. The Advisory Committee will be composed of stakeholders, including providers, insurers, employers and consumers. By requiring the

²⁰ Behavioral economic research has demonstrated that people strongly prefer avoiding losses than acquiring gains. Some studies suggest that losses are as much as twice as psychologically powerful as gains. See, “Loss Aversion – Behavioral Finance” for a summary of research and listing of published research articles. Available at: loss-aversion.behaviouralfinance.net

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Commissioner to convene a multi-stakeholder Care Transformation Advisory Committee, the regulations continue the Rhode Island regulatory model of engaging stakeholders who are impacted by the regulatory requirements to participate in shaping how those requirements will be met. This model was used successfully to implement the CTC-RI initiative for which stakeholders worked with OHIC to develop a common PCMH transformation delivery model and payment methodology.

Two examples are included in this Standard of the types of transformation support that might be provided; both are generally-accepted approaches to promoting transformation, particularly among small practices. Vermont and North Carolina are two states with many small practices that have implemented community-based care management teams that provide shared care management services to numerous practices. Both states have been able to significantly reduce inappropriate care and realize reduced health care costs.²¹ Practice coaches have been used successfully by many PMCH transformation initiatives, including those in Massachusetts, Vermont and Missouri, to provide hands-on guidance to practices moving through the stages of transformation.

Standard No. 3 - Payment Reform.

OHIC's payment reform strategy includes the following key components: promoting population-based contracting, adoption of alternative payment methodologies, improved hospital contracting practices, and limiting cost increases associated with population-based contracts entered into by Integrated Systems of Care (also known as Accountable Care Organizations ("ACOs")).

Payment Reform - Population-Based Contracting.

After reviewing both national and state-specific experience, OHIC has concluded that improving affordability of health care services can best be promoted by building on the current market trends and supporting the development of Population-based Contracting with ACOs. Moreover, drawing on experience in other states, OHIC has found that to have an impact on the delivery of care in Rhode Island, the reach of ACOs must be significant and the ACOs need to move beyond shared savings arrangements.²² This Standard in the Adopted Regulation promotes population-based contracting by establishing contracting targets for Health Insurers.

The Adopted Regulation defines a Population-Based Contract as a "provider reimbursement contract that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered-lives population." The requirement that the contract is inclusive of the total, or near total medical costs of an

²¹ C Bielaszka-DuVernay, "Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at Lower Costs." *Health Affairs*, March 2011, vol. 30, no. 3, 383-386. Available at: <http://content.healthaffairs.org/content/30/3/383.extract>; Information on savings attributed to North Carolina's Community Care of North Carolina initiative is available at: <http://commonwealth.communitycarenc.org/about/overview.aspx>.

²² BK Larson, AD Van Citters, SA Kreindler, et al. "Insights from Transformations under way at Four Brookings-Dartmouth Accountable Care Organization Pilot Sites." *Health Affairs*, November 2012, vol. 31, no. 11 2395-2406. Accessed on December 29, 2014 at: <http://content.healthaffairs.org/content/31/11/2395.short>.

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identified, covered-lives population is intended to create incentives for the providers participating in the contract to assume responsibility for managing all the care provided to the identified population. ACOs are expected to focus on improving the health of a defined population by identifying risk factors and tailoring health care interventions to address those risk factors. OHIC further anticipates that ACO population health management strategies will emphasize evidence-based practices and improved outcome achievement.²³ The definition specifically excludes primary care or specialty service capitation reimbursement contracts from the definition of Population-Based Contract because those contracts do not cover total or near total medical costs.

Providers in ACOs with Population-Based Contracts have motivation to provide unreimbursed services, such as proactive patient outreach activities or team meetings to discuss complex patients, in order to reduce avoidable and inappropriate service utilization, and thereby generate savings. Unlike PCMHs, which include only primary care practices, ACOs can include providers across the continuum of care including institutional providers, such as hospitals. Therefore, savings from better managed care, such as reduced inpatient utilization, can be realized by an ACO and re-invested in population health management infrastructure and/or paid out to ACO-participating providers as rewards. This opportunity for realizing gained savings provides an incentive to provide coordinated, integrated care that focuses on maintaining and improving the health of the covered population. By creating incentives to provide integrated, coordinated care, Population-based Contracts are directly countering the siloed, volume-driven incentives of fee-for-service payments which have resulted in inappropriate utilization and high health care inflation rates.

Nationally, ACOs operating under Population-Based Contracts are developing within both the commercial and publicly funded health insurance markets. CMS has two initiatives to promote Population-based Contracting. Its Medicare Shared Savings Program has over 300 ACOs and over 13,800 providers participating nationally.²⁴ Its Medicare Pioneer ACO initiative, which involves upside and downside risk, has 23 participants nationally. Currently there are four emerging commercial ACOs in Rhode Island that are engaging in Population-based Contracting: ACOs operated by Care New England, Lifespan, Rhode Island Primary Care Physicians Corporation and Coastal Medical of Rhode Island. These four ACOs currently provide primary care services to over 10% of Rhode Island residents. None currently accept downside risk. Rhode Island has one Medicare Shared Savings Program ACO involving Coastal Medical of Rhode Island.

²³ D. Krewski, v. Hogan, M Turner, et. Al. "An Integrated Framework for Risk Management and Population Health." *Human and Ecological Risk Assessment*, 13:1288-1312, 2007. Accessed on December 22, 2014 at: www.tandfonline.com/doi/abs/10.1080/10807030701655798#preview. M. Ibrahim; L. Savitz, et. Al. "Population-based Health Principles in Medical and Public Health Practice." *Journal of Public Health Management & Practice*, May 2001. Accessed on December 22, 2014 at: http://journals.lww.com/jphmp/Abstract/2001/07030/Population_Based_Health_Principles_in_Medical_and_Public_Health_Practice.aspx

²⁴ <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/pfam-u3vp>

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The most recent quality and cost results released by CMS on September 16, 2014 showed that the Medicare ACOs have successfully improved the quality of care for Medicare beneficiaries and improved patient experience. The ACOs also generated \$417 million in savings for CMS and qualified for shared savings payment of \$460 million.²⁵

Blue Cross Blue Shield of Massachusetts (“BCBSMA”) launched a Population-based Contracting initiative, referred to as its Alternative Quality Contract (“AQC”), in 2009 and provides timely and comparable experience as to the potential benefits of Population-based Contracting. A recent peer-reviewed study of the performance of ACOs under the AQC found that by the end of 2012 those signing AQC contracts in 2009 generated savings of 6.8%; those signing in 2010 generated savings of 8.8%; those signing in 2011 generated savings of 9.1% and those signing in 2012 generated savings of 5.8%. The saving amounts were statistically significant at a P=0.001 level for 2009 through 2011 and at a P=0.04 level for 2012. Savings resulted from reduced utilization and reduced prices in the outpatient facility setting and in procedures, imaging and tests. Incentive payments exceeded claims savings during 2009 through 2011, but the ACOs generated net savings in 2012. Improvements in quality among the participating ACOs generally exceeded improvements seen in New England and nationally.²⁶ This Massachusetts provider experience indicates clearly that successful delivery system transformation under an ACO population-based contract is possible, particularly when the ACOs are accepting downside risk. It also indicates that care delivery transformation takes time to generate net savings. OHIC’s population-based contracting targets have taken these findings into account, as the targets are modest and increase only gradually in terms of both the percentage of total insured covered lives attributed to Population-Based Contracts and the percentage attributed to Population-Based Contracts with downside risk.

Finally, this Standard requires Health Insurers to file standard operating procedures with OHIC that address how they will assess the Integrated System of Care’s ability to assume downside risk before entering into such a contract. This is an important consumer protection provision, in order to ensure that Health Insurers are contracting with financially viable providers that will be able to fulfill the coverage promises made in the health insurance plan. Health Insurers in more mature markets routinely make these assessments in order to protect their covered lives against a potentially disruptive Integrated System of Care failure. OHIC finds it reasonable and necessary to require the same level of due diligence activity by Rhode Island Health Insurers.

Payment Reform - Alternative Payment Methodologies.

There is wide consensus among health services researchers, economists, and industry leaders that fee-for-service (“FFS”) reimbursement for medical care is a key driver of

²⁵ Fact sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth. September 16, 2014. Accessed on December 29, 2014 at: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html

²⁶ S. Zirui, S Rose, DG Safran, B Landon, MP Day, ME Chernew. “Changes in Health Care Spending and Quality 4 Years into Global Payment.” *N Engl J of Med* 2014; 371: 1704-1714, October 30, 2014. Accessed on December 22, 2014 at: www.nejm.org/doi/full/10.1056/NEJMsa1404026

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total medical spending.²⁷ It is acknowledged that FFS reimbursement presents financial incentives for volume generation and increased service intensity.²⁸ FFS also results in fragmentation of care, which may lead to unnecessary service delivery and poor health outcomes for patients with chronic health conditions. FFS reimbursement, as a driver of unnecessary medical spending, represents a challenge to the affordability of health insurance for Rhode Island consumers.

Nationally, focus has shifted to alternative payment methodologies (“APMs”) as a way to realign provider incentives to deliver care more efficiently and explicitly link payment to value. APMs include prospective global payment (sometimes referred to as global capitation), primary care capitation, bundled (or episode-based) payments, pay-for-performance bonus, and per member per month supplemental payments. Population-Based Contracts typically utilize a hybrid of global payment and FFS by comparing provider performance on total cost of care and clinical quality for a defined population to a set of predetermined cost and quality targets.

In Rhode Island in 2013, only 4.7% of commercial payments for hospital inpatient and outpatient services were made through alternatives to FFS.²⁹ In the primary care sector, approximately 40% of payments are made through non-FFS methods, with a large portion of these payments consisting of supplemental payments made on a per member per month basis to fund PCMH transformation and incentive payment distributions for quality performance.³⁰

Determining the optimal mix of payment methodologies for a market is not a straightforward task. A number of relevant factors, including the distribution of insurance product types (HMO vs. PPO) across commercial policyholders, and delivery system factors, such as the average size of physician group practices and provider readiness to manage risk, are important. For this reason the Commissioner will convene an Alternative Payment Methodology Committee, consisting of payers, providers, consumers, employers and other stakeholders to develop an annual payment transformation plan designed to increase the use of alternative payment methodologies for provider reimbursement. The Committee will convene by March 2015, and by October 1st annually thereafter.

Payment Reform - Hospital Contracting.

²⁷ A recent report by the Miller Center at the University of Virginia identifies FFS reimbursement as key contributor to the high cost of medical care in the United States. “Cracking the Code on Health Care Costs: A Report by the State Health Care Cost Containment Commission.” The Miller Center. University of Virginia. January 2014. Available at:

<http://web1.millercenter.org/commissions/healthcare/HealthcareCommission-Report.pdf>

²⁸ FFS payments with volume-based incentives include negotiated unit of service payments, inpatient diagnosis-related groups (DRGs), outpatient ambulatory patient groups (APGs), and per-diem payments.

²⁹ Information obtained by request from BCBSRI, United HealthCare of New England, and Tufts Health Plan. The number represents payments pooled across the three major commercial insurers and includes payments for self-insured membership.

³⁰ Information obtained from insurer quarterly primary care spend reports.

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Reimbursement rates paid by commercial Health Insurers for hospital services are determined through private negotiations. This system for negotiating prices and rates of price increase occurs outside of a formal mechanism considering the public interest affected, and has important implications for health insurance premiums. Based on data filed with OHIC during the 2014 rate review process, 48.4% of medical costs are incurred in hospital inpatient and outpatient settings. Hospital inpatient and outpatient claims costs are determined by a combination of utilization, service mix, and pricing trends.

The Rhode Island market for hospital services is highly concentrated.³¹ Market concentration gives hospitals increased negotiating leverage with respect to Health Insurers, thus enhancing the ability of hospitals to increase prices. The price increase limitation required by OHIC mitigates the effect of hospital price inflation on premiums by increasing the leverage of insurers in contract negotiations.

Based on interviews conducted for a 2013 evaluation of the Affordability Standards³², funded by OHIC, “BCBSRI and United reported that prior to OHIC implementing the [price increase limitation], they possessed very little leverage over larger hospitals to curb rate increases. For them, therefore, the cap shifted negotiating leverage to the insurers.” These interviews provided evidence that the price increase limitation has been effective at balancing leverage between insurers and hospitals and therefore at moderating price inflation.

In 2010, in response to concerns over the impact of price inflation for hospital inpatient and outpatient services on premiums, OHIC designed a set of hospital contracting standards for insurers, known collectively as the Hospital Contracting Conditions. These conditions support affordable health insurance by making the approval of insurer rate filings contingent on the Health Insurer’s agreement to abide by contracting standards with hospitals that limit service price inflation, improve the quality of care, and work towards increased administrative efficiencies.

The Hospital Contracting Conditions existing prior to the Adopted Regulation advance two important payment reform objectives: first, they limit average annual effective rates of price increase for both inpatient and outpatient services to no more than a weighted amount equal to increases in the CMS National Prospective Payment System Hospital Input Price Index (“IPPS”) plus 1%, for all contractual and optional years covered by the contract; and second, they require that insurer contracts with hospitals include a quality incentive program, and that at least 50% of the annual price increase for hospitals must be

³¹ A 2010 study of variation in payment to RI hospitals, jointly funded by OHIC and the Executive Office of Health & Human Services (EOHHS), found that RI’s hospital market was “highly concentrated” according to standards used by the federal Department of Justice to evaluate the effect of mergers on competition (the Herfindahl Hirschman Index). Additionally, there are significant inpatient service concentrations in RI, particularly obstetrics and pediatric care. See “Variation in Payment for Hospital Care in Rhode Island.” Prepared for the Rhode Island Office of the Health Insurance Commissioner and the Rhode Island Executive Office of Health and Human Services. December 19th, 2012. Xerox. Available at: www.ohic.ri.gov/2012%20Rhode%20Island%20Hospital%20Payment%20Study.php

³² Assessment of the RI Office of the Health Insurance Commissioner’s Affordability Standards. Final Report, 2014. Available at: <http://www.ohic.ri.gov/2013%20Affordability%20Standards%20Report.php>

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earned through performance on a mutually-agreed to set of quality measures. Interviews conducted for the 2013 evaluation found that the quality incentive requirements for insurer contracts produced a “culture shift” within hospitals, by focusing increased attention to outcome measures of quality. Furthermore, the “at least 50%” provision was determined to be necessary so that price increases in excess of the price index are not included in the contract under the guise of a quality performance payment.

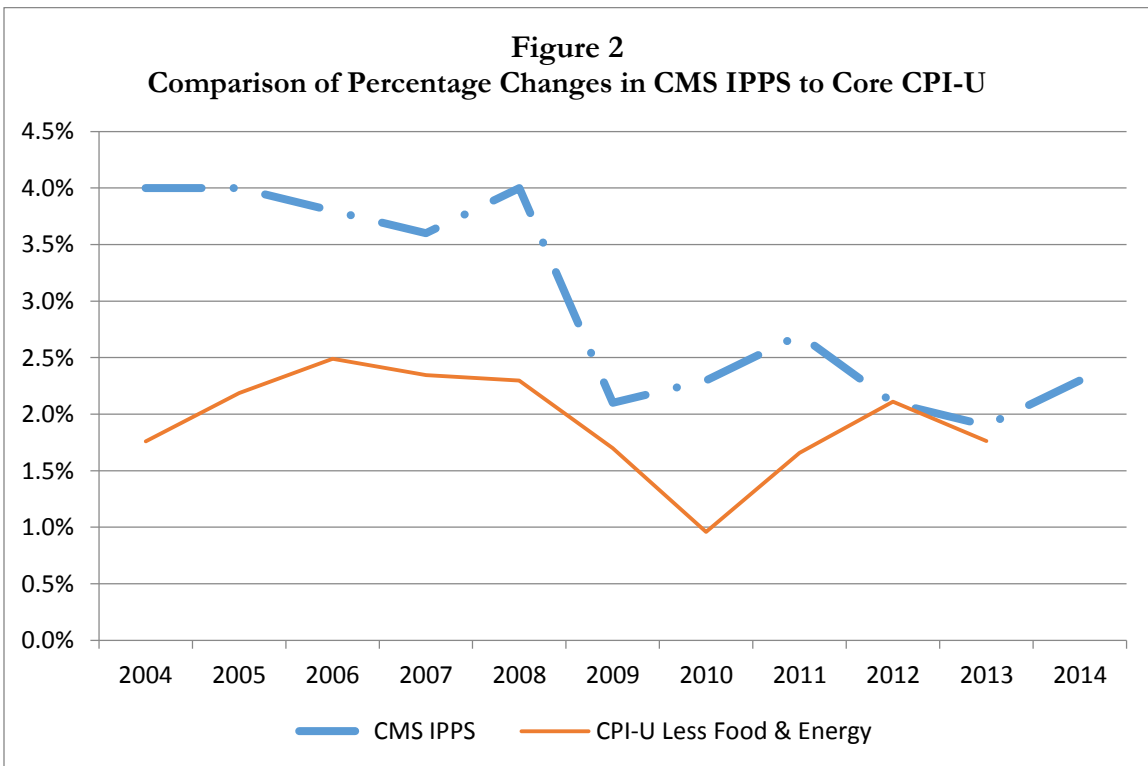
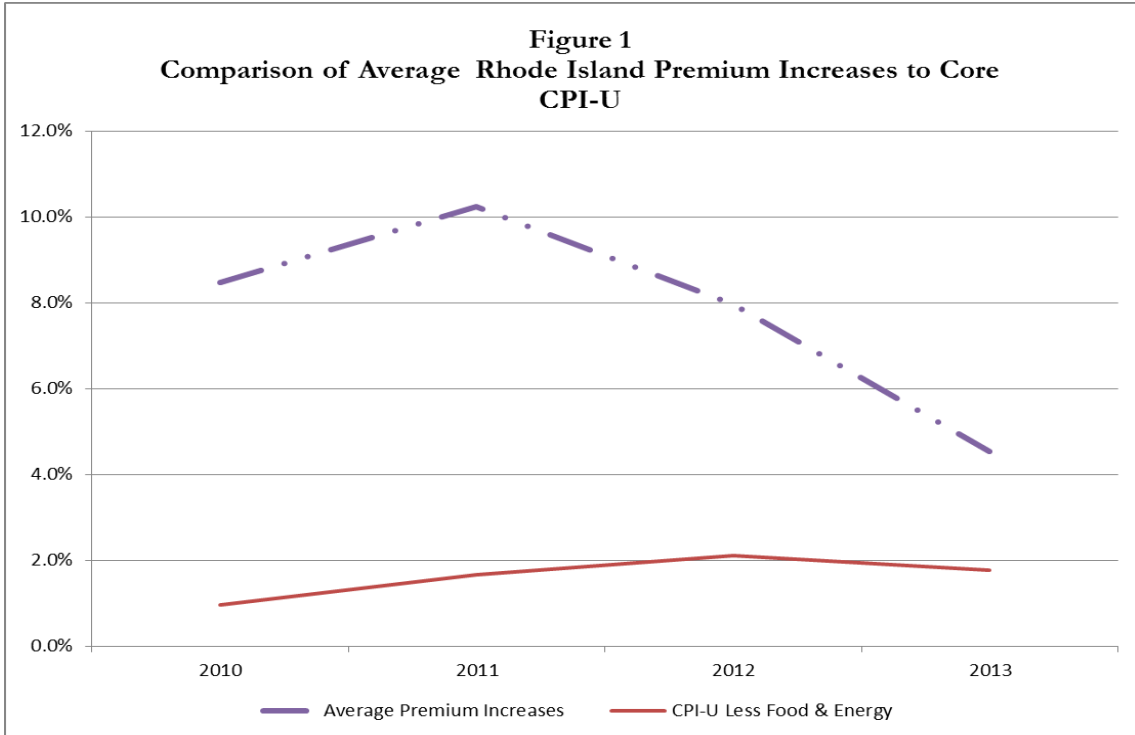
The Hospital Contracting Standard of the Adopted Regulation retains a limitation on hospital rate increases, because health insurance premiums, and many of the factors underlying those premiums, including price inflation for hospital inpatient and outpatient services, have increased faster than core inflation for the economy as a whole, as shown in Figures 1 and 2.³³

The Standard replaces the CMS IPPS index with the national Consumer Price Index for Urban Consumers (less Food and Energy) (“Core CPI-U”) as the reference index to set the price increase limitation, because Core CPI-U is a more meaningful metric of changes in the cost of living faced by consumers. Moreover, as indicated in Figure 2, the Core CPI-U index is a more stable benchmark than the CMS IPPS, and percentage changes in the Core CPI-U have, historically, run below percentage changes in the CMS IPPS. Therefore, the adoption of Core CPI-U for setting the price increase limitation for hospital services will provide a more stable benchmark, provide additional downward pressure on hospital pricing trends, and enhance OHIC’s health insurance affordability objective.

The Proposed Amendments proposed Core CPI-U for the Northeast region as the reference inflation index for implementation of the hospital price increase limitation. After further consideration, OHIC has chosen to adopt the national Consumer Price Index for Urban Consumers (less Food and Energy) because it tracks quite closely to the Core CPI-U for the Northeast region, but is more stable, as measured by the standard deviation. Furthermore, adoption of the Core CPI-U as the reference index creates alignment with OHIC’s adopted contracting standards for budget increases for population-based contracts, as described below.

³³ The average premium increases shown in Figure 1 represent arithmetic averages of Rhode Island small and large group market average premium increases for the years shown.

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Payment Reform Standard - Limits on Population-Based Budget Increases.

This Standard in the Adopted Regulation establishes a set of requirements for Health Insurers when entering into Population-Based Contracts. These requirements are similar in some respects to the Hospital Contracting Standard, but apply to contracts between Health Insurers and Integrated Systems of Care. Whereas the Hospital Contracting Standard limits annual hospital rate increase, this Standard limits annual budget increases for population-based contracts.

The rationale for a budget increase limit is similar to the rationale for a limit on hospital rate increases - to reduce health care and health insurance inflation below what would otherwise result if medical inflation were allowed to proceed without limitation. OHIC recognizes that nationally the formation of ACOs appears to have driven further consolidation in the provider market, especially with hospital acquisition of physician practices. Consolidation can enhance the ability of providers to manage population health through improved coordination of patient care.³⁴ However, consolidation also increases providers' leverage in contract negotiations with insurers, potentially increasing prices and driving up total medical expenditures. A recent study based on HMO enrollees in California found that total annual patient medical expenditures were significantly higher for patients attributed to hospital-owned and multi-hospital system-owned physician practices relative to physician-owned practices.³⁵ A total budget increase limitation on population-based contracts will help mitigate the inflationary effect of provider consolidation on total medical expense and insurance premiums.

C. Comments Received and OHIC Responses.

The following section describes the public comments that OHIC received in response to the proposed revisions to Regulation 2 released on November 5, 2014.³⁶

General Comments.

1. BCBSRI comments that the regulation is overly prescriptive and limits health insurer flexibility and management discretion while requiring carriers to seek input or approval from the Commissioner.

OHIC Response. OHIC respectfully disagrees with this comment. While the Adopted Regulation certainly does contain a set of standards which Health Insurers

³⁴ RA Berenson, PB Ginsburg, JB Christianson, T Yee. "The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed." *Health Affairs*, May 2012, vol. 31, no. 5 973-981. Accessed on January 25, 2015 at:

<http://content.healthaffairs.org/content/31/5/973.abstract>

³⁵ JC Robinson, K Miller. "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California." *JAMA*. 2014;312(16):1663-1669. doi:10.1001/jama.2014.14072.

³⁶ Proposed revisions to Regulation 2 available here:

http://www.ohic.ri.gov/documents/Insurers/Regulations/Regulation%20%20proposed%20amendments/2_Regulation%20%20proposed%20amendments.pdf

Public comment in response to revised Regulation 2 (released November 5, 2014) available here:

http://www.ohic.ri.gov/documents/Insurers/Regulations/Regulation%20%20proposed%20amendments/4_Final%20Reg%20%20Comments%20121014.pdf

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are obligated to comply with, the magnitude of the task of reforming how health care is delivered in Rhode Island, and the significant negative impact from the rising cost of health insurance on the Rhode Island economy call for the establishment of meaningful care transformation and payment reform requirements. In those instances where the Adopted Regulation calls for the Commissioner's approval, for example in connection with infrastructure development that is countable as direct primary care spending, the approval provision is a more flexible alternative to comprehensively and prescriptively defining direct primary care spending. The "Commissioner's approval" approach will permit greater flexibility and the opportunity for innovation by Health Insurers and Providers.

2. BCBSRI comments that the regulations continue to hold carriers solely responsible through the rate review process for affordability and payment reform and that the rate review process is not the vehicle through which to set healthcare policy.

OHIC Response. The Legislature has charged OHIC to "encourage policies and developments which improve the quality and efficiency of health care service delivery and outcomes" and "view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access".³⁷ OHIC has construed these legislative purposes to include a responsibility to promote the affordability of health insurance for all Rhode Island residents and businesses through its rate review process which charges the Commissioner with considering whether a carrier's proposed rate increase is consistent with "proper conduct of its business and the interests of the public". For a more comprehensive analysis of OHIC's authority to adopt this Regulation, see the Concise Statement issued in connection with the 2012 amendments to Regulation 2.³⁸

3. BCBSRI recommends the Commissioner leverage the existing framework of the Healthcare Leaders Workgroup to inform the development of the Affordability Standards in order to ensure that the proposed regulations do not work at cross-purposes to the Compact adopted by the Workgroup.

OHIC Response. OHIC has been heavily involved in the drafting and development of the Healthcare Leaders Workgroup Compact. The adopted regulations are not in contradiction with the Compact and represent one tool to help accomplish the goals outlined in the Compact.³⁹

4. Lifespan and BCBSRI recommend delaying the adoption of the proposed regulations.

³⁷ R.I. Gen. Laws § 42-14.5-2.

³⁸ http://www.ohic.ri.gov/documents/Insurers/Regulations/Regulation%2020Final%2092812/1_Concise%20Summary%20of%20Adopted%20Regulation%2020Effective%2092812.pdf

³⁹ The adopted Compact of the Workgroup can be found at http://www.ohic.ri.gov/documents/Committees/HIAC/2015%20January%20Materials/3_Health%20Care%20Leaders%20Compact.pdf

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OHIC Response. The crisis in health care and health insurance affordability facing Rhode Island, and the impact of affordability on a Rhode Island economy still seeking to recover from the most recent recession requires that steps be taken without delay.

5. Lifespan is concerned about the broad authority given to the Commissioner to change or waive requirements. Lifespan comments that this broad authority can create role confusion and inserts OHIC into various hospital contracts by claiming certain contract provisions impact the Affordability Standards.

OHIC Response. The central concepts of the Hospital Contracting Standards, including an annual limitation on hospital price increases, have not changed in the Adopted Regulation. While the price index against which price increases are compared has changed in the Adopted Regulation, the concept of a price limitation, and the ability of Health Insurers to seek a waiver from the application of the price limitation has not changed. If the annual price increase in a hospital contract is below the reference price, no involvement with OHIC is necessary. It is only if the price increase exceeds the price increase limitation, or some other requirement of the Standard is not included in the hospital contract, that the approval of the Commissioner is necessary. This approach and process maintain the integrity of the Standard, but also allow for flexibility in extraordinary circumstances justifying a waiver of the requirement.

Specific Comments.

6. **Section 3(c) and Section 3(i). Direct and Indirect Primary Care Expenses.** BCBSRI comments that the regulations currently limit the flexibility of the health insurer to decide on which investments are most appropriate to make in primary care. Specifically, BCBSRI comments that the regulations do not appear to allow as either direct or indirect expenses, investments in data, analytics or population health tools which will support advancements in primary care, care coordination and movement towards integrated systems of care. UnitedHealthcare (“United”) comments that direct primary care spending should include payments to a facility-based or medical group-based ACO that directly supports a primary care practice and include infrastructure payments to ACOs that help develop the capacity for services such as providing case managers, hospitalist services, or other administrative services.

OHIC Response. OHIC agrees with some, but not all of the suggestions made by the commentators. The Adopted Regulation includes within the definition of Direct Primary Care Expenses investments in tools that will benefit primary care practices, and the expense of case managers directly benefiting primary care practices. The Adopted Regulation also provides greater clarity and specificity to Health Insurers on this matter. Furthermore, if a Health Insurer has a specific request about whether an investment will count as Direct or Indirect Primary Care Spend under this Standard, the Commissioner will entertain Health Insurer requests which are consistent with the purposes of the Adopted Regulation. On the other hand, OHIC does not support counting as Direct Primary Care Spending Health Insurer expenses which do not

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significantly and directly assist primary care practices to be successful in their care transformation efforts.

7. **Section 3(f). Global Capitation Contract.** CharterCare requests that a “global capitation contract” be included as a type of Population-Based Contract.

OHIC Response. OHIC agrees with this comment, as reflected in the Adopted Regulation.

8. **Section 3(j). Integrated System of Care.** BCBSRI comments that Integrated Systems of Care should not be limited to legally constructed entities and the regulations should also recognize and support virtual integration through contractual arrangements.

OHIC Response. OHIC agrees with this comment, as reflected in the Adopted Regulation.

9. **Section 3(k). Patient-Centered Medical Home.** (1) BCBSRI comments that the regulations appear to prohibit a health insurer from entering into alternative arrangements with primary care and integrated systems of care without the approval of the Commissioner, which would be unduly burdensome. (2) The Rhode Island Parent Information Network (“RIPIN”) is concerned that allowing Advanced Primary Care Practices (APCPs) to count as PCMHs will lower the PCMH standards and not achieve the desired outcomes and that there will be disparities in care if APCPs don’t provide the same level of care and care coordination as nationally accredited PCMHs. (3) United would like the definition of PCMH to be broadened to include other types of organizations such as ACOs that may also function as a PCMH or provide direct support to a PCMH. (4) The Providence Center notes that the regulations should call for integrated behavioral healthcare to be a central part of every PCMH, including allowing Community Mental Health Centers to be a PCMH for patients.

OHIC Response.

(1) OHIC respectfully disagrees with BCBSRI’s comment, but the Adopted Regulation has been revised to clarify the purpose of these provisions. With respect to a “contractually-designated primary care practice”, the performance standards of the designated practice must be approved by the Commissioner, in order that the fundamental goals of care transformation are achieved; however, the actual contract with the designated practice that qualifies it for PCMH purposes does not need to be approved by the Commissioner. With respect to Integrated Systems of Care, the Adopted Regulation has been revised to permit greater flexibility in the development of Integrated Systems of Care.

(2) OHIC recognizes RIPIN’s concern and has added language in the Adopted Regulation to require care management and coordination requirements for contractually designed practices to be at least as rigorous as those of the collaborative initiative endorsed by R.I.G.L. Chapter 42-14.6.

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(3) The purpose of this primary care standard is to emphasize and encourage the support and transformation of primary care. PCMHs can include alternative arrangements that still meet the care coordination and management of a nationally accredited PCMH as long as the focus is on primary care.

(4) OHIC agrees that behavioral healthcare is an essential part of integrated care, and the Adopted Regulation has been revised to incorporate this goal. The Adopted Regulation specifically states that “Specialty medical providers, including behavioral health providers may be designated as a primary care provider if the specialist is paid for primary care services on a primary care provider fee schedule, and contractually agrees to accept the responsibilities of a primary care provider” in the definition of a “Primary Care Practice”. The Adopted Regulation does not prohibit community mental health centers acting as PCMHs, if PCMH standards are met.

10. **Section 3(m). Primary Care Practice.** BCBSRI disagrees with including physicians with a dual specialty in the definition of “primary care practice” and suggests removing that language.

OHIC Response. OHIC respectfully disagrees. If a specialty medical provider is paid for primary care services on a primary care provider fee schedule and contractually agrees to accept the responsibility of a primary care provider, they should be considered a primary care provider, because their primary care-related activities support the care transformation goals of the Adopted Regulation.

11. **Section 10(a).** (1) Delta Dental comments that the definition of health insurer as written is too broad and recommends adding an exclusion for “Health Insurers” that are non-profit dental service corporations, or non-profit optometric service corporations. (2) United comments that OHIC should define covered lives more narrowly as fully-insured covered lives under RI-issued policies.

OHIC Response. OHIC agrees with both of these comments. The Adopted Regulation includes revisions that address the comments.

12. **Section 10(b). Primary Care Spend Obligation.** United objects to the statement that the regulations will be used to “ensure” sufficient financial support for primary care providers in Rhode Island and believes that this is beyond the powers and duties of the Commissioner. United suggests that OHIC should use the word “encourage” instead of “ensure”.

OHIC Response. The Adopted Regulation has been clarified to address the concern expressed by this comment. The Primary Care Spend Standard is intended to address financial support for primary care practices only as necessary to achieve the statutory affordability mission of OHIC.

13. **Section 10(b)(1)(A). Primary Care Spend Obligation.** (1) Lifespan comments that it would like a more fulsome discussion about direct primary care spending and is concerned about the physician network implication for providers, specifically those

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that are part of a health care system. (2) United comments that the applicability of payments for the administrative expenses of the medical home initiative endorsed by RIGL Chapter 42-14.6 and the health information exchange established by RIGL Chapter 5-37.7e should extend beyond 2014 unless the requirement for insurers incurring such payments is discontinued for later years. (3) BCBSRI comments that OHIC has no authority to require on-going payments to CurrentCare as this is equivalent of a tax which is not delegated to OHIC by the General Assembly. (4) BCBSRI also comments that OHIC should eliminate the requirement that investments be split between direct and indirect primary care spend. The proposed regulations would require BCBSRI to shift money from direct primary care spend to indirect primary care spend.

OHIC Response.

(1) The Commissioner welcomes continued discussion with all stakeholders concerning affordability. The Care Transformation Advisory Committee should provide a useful forum in which to continue these discussions.

(2) OHIC administrative expenses of the medical home initiative endorsed by RIGL Chapter 42-14.6 will continue to count as Indirect Primary Care Expense. With respect to the health information exchange established by RIGL Chapter 5-37.7e, OHIC anticipates a Commissioner's review in 2015 of progress in provider and patient participation. Whether this obligation will continue beyond 2015 will depend upon the results of that review.

(3) OHIC respectfully disagrees with this comment. The Legislature has conferred broad authority on OHIC to approve, disapprove, or modify rates filed by Health Insurers.⁴⁰ OHIC's rate approval authority includes the power to review a Health Insurer's administrative costs, after considering whether those costs are reasonable and appropriate. This provision in the Adopted Regulation merely codifies in regulatory language how the Commissioner intends to review the allocation of administrative costs for a program that can benefit all ratepayers.

(4) OHIC has addressed the concern expressed by this comment by revising the Standard to remove a minimum floor on Health Insurers' Indirect Primary Care Spend Obligation.

14. **Section 10(b)(1)(B). Primary Care Spend Obligation.** United comments that any reassessment of primary care spend should not result in any increase of the percentages set forth in the preceding subsection. United comments that the Commissioner should consult with and get the agreement of the affected health insurers on any such reassessment.

OHIC Response. The Adopted Regulation has been revised to include consultation with stakeholders. If the results of the national survey warrant a change in the Primary Care Spending obligation, because a revised requirement is more efficient or effective in advancing the care transformation goals of the Affordability Standards, it is reasonable to make such revisions. Any such revisions will be adopted through the rate review process, in order that the revisions are made in fair and open process.

⁴⁰ R.I. Gen. Laws § 42-62-13.

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15. **Section 10 (b)(3) Primary Care Spend Obligation.** United comments that the Commissioner does not have the jurisdiction to mandate fully insured payment level applications to self-funded plans and non-commercial plans.

OHIC Response. The Adopted Regulation does not apply any requirement of the Affordability Standard to any other than insured plans; however, the Adopted Regulation prohibits Health Insurers from imposing on insured plans the entire costs of initiatives that benefit all plans.

16. **Section 10(c). Primary Care Transformation.** United believes that the primary care transformation targets should be goals.

OHIC Response. OHIC disagrees with this comment, and believes the need for affordable health insurance requires that clear, binding expectations be established in the Adopted Regulation.

17. **Section 10(c)(1). Primary Care Transformation.** CharterCare requested that Integrated Systems of Care be considered as a PCMH for purposes of the Care Transformation Standard.

OHIC Response. OHIC respectfully disagrees that any Integrated System of Care should be included as a PCMH for the purposes of the Care Transformation Standard. An Integrated System of Care may include PCMH practices, but it is unlikely that a PCMH can incorporate the contractual, care management, and analytical functions of an Integrated System of Care.

18. **Section 10(c)(2)(C). Primary Care Transformation.** BCBSRI objects to the requirement that payers fund a care transformation plan based on a formula established by the Commissioner and believes that OHIC has no authority to impose such a financial responsibility under applicable law. United comments that funding for care transformation plans should include other sources besides insurer assessments. Since transformation benefits the community at large, United does not believe that the Commissioner has the jurisdiction to assess health insurers for this purpose absent clear legislative authority.

OHIC Response. OHIC respectfully disagrees with these comments. The Legislature has conferred broad authority on OHIC to approve, disapprove, or modify rates filed by Health Insurers.⁴¹ OHIC's rate approval authority includes the power to review a Health Insurer's administrative costs, after considering whether those costs are reasonable and appropriate. This power includes both the power to reject unreasonable and excessive administrative costs, as well as the power to disapprove filed rates if the Health Insurer's administrative cost request does not include the funding of health system improvements that will benefit all of the Health Insurer's subscribers. If a health care initiative such as the Care Transformation Standard

⁴¹ R.I. Gen. Laws § 42-62-13.

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initiative can be demonstrated to support progress towards affordable health insurance in Rhode Island, as the Commissioner believes to be the case with the Care Transformation initiative, then the expenses associated with the initiative are reasonable and “consistent with the interests of the public”.

19. **Section 10(c)(2) and Section 10(d)(2)(c). Primary Care Transformation and Alternative Payment Methodologies.** BCBSRI proposes eliminating the new committees responsible for adopting a care transformation plan and an alternative payment methodology plan and using the Healthcare Leaders Workgroup to obtain input.

OHIC Response. While the Healthcare Leaders Workgroup, in which the Commissioner participates, is a valuable force for health reform in Rhode Island, there is a legitimate role for a regulator such as OHIC to ensure that the Workgroup’s health reform voluntary goals are achieved, and that goals and commitments are applied consistently among stakeholders. While OHIC anticipates an ongoing conversation with the Healthcare Leaders Workgroup about the progress and content of the Affordability Standards, OHIC’s new committees have a different charge than the Healthcare Leaders Workgroup. OHIC anticipates that stakeholder representation on these committees will closely align with the representation on the Workgroup.

20. **Section 10(c)(2) and Section 10(d)(2)(c). Primary Care Transformation and Alternative Payment Methodologies.** BCBSRI comments that the proposed timing for the care transformation and alternative methodology plan coincides with the preparation and submission of the annual rate filings. BCBSRI comments that information would ideally be known by December 31st of each year to be included in annual filings.

OHIC Response. OHIC agrees with this comment, and has revised the Adopted Regulation accordingly to more closely align with health insurer timelines for budget development, and with annual form and rate filings with OHIC.

21. **Section 10(d)(1)(A) through (C). Population-Based Contracting.** The Hospital Association of Rhode Island (“HARI”) comments that the fixed percentages on yearly risk-based contract targets may not adequately provide the flexibility providers may seek or need.

OHIC Response. The Adopted Regulation includes a mechanism for OHIC to solicit comment and suggestions from stakeholders on all of the annual targets established in the Affordability Standards.

22. **Section 10 (d)(1)(c). Population-Based Contracting.** BCBSRI recommends including targets for population based contracting only for 2015 and 2016 with 2017 targets to be set later because the proposed 2017 targets may be too aggressive. BCBSRI is also unclear as to what the ramifications would be if a Health Insurer were unable, despite reasonable diligence, to achieve these targets.

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OHIC Response. OHIC agrees with the comment regarding the 2017 target for population-based contracting. The Adopted Regulation defers on setting a 2017 target until progress can be reviewed. With respect to ramifications or regulatory consequences, the Section 10(e)(2) of the Adopted Regulation establishes standards and a process by which Health Insurers will not be held accountable in circumstances where it would be inappropriate to do so.

23. **Section 10(d). Payment Reform.** United comments that the percentage targets in this section should be goals.

OHIC Response. OHIC respectfully disagrees with this comment, and believes that it is important to set binding targets and clear expectations in order to achieve the goals of the Affordability Standards.

24. **Section 10(d). Payment Reform.** United questions the use of the term “rating manual” in Section 10(d)(1)(D).

OHIC Response. OHIC agrees with this comment. The Adopted Regulation requires Health Insurers to file with the Commissioner its standard operating procedures relating to provider assumption of risk, but the filing need not be part of the rate manual.

25. **Section 10(d)(1)(D). Population-Based Contracting.** BCBSRI comments that requiring Health Insurers to assess financial viability of an ACO imposes a significant burden and is based on false assumptions that operating procedures in rating manuals contain procedures for evaluating the financial viability of providers, and that Health Insurers have the expertise or access to necessary information. BCBSRI suggests that this section should be deleted in its entirety and, instead, legislation should be sought to give OHIC authority for the oversight of solvency of such provider organizations. United comments that the list of elements to consider in this section should not be exclusive; a health insurer may have other criteria it uses. United also comments that the Adopted Regulation should make clear that even if a provider meets these financial viability standards, the Health Insurer should not be obligated to enter into a population-based contract.

OHIC Response. OHIC agrees with some, but not all of these comments. The Adopted Regulation calls for a Health Insurer’s financial viability evaluation standards to be filed and approved by the Commissioner in a process that is distinct from the rating manual review process. The Adopted Regulation directs the Health Insurer to evaluate the provider’s financial viability, but defers to the Health Insurer for the initial development of evaluation standards. However, because the Adopted Regulation does not require, either explicitly or by implication, a Health Insurer to contract with a provider simply because the provider has met the Health Insurer’s financial viability criteria, no additional clarification is needed.

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26. **Section 10(d)(2)(A) or(C). Population-Based Contracting.** Lifespan proposes an aggressive approach to transition to alternative risk models (ARM's) by 2016. Lifespan also comments that these targets should align with the SIM effort, and notes the need to develop metrics and processes to measure progress and success.

OHIC Response. OHIC is sympathetic to these comments, but believes the work of the Alternative Payment Methodology Committee is the proper vehicle to address these issues.

27. **Section 10 (d)(2)(B) Alternative Payment Methodologies.** BCBSRI proposes flexibility for Health Insurers to use APMs that may not be nationally recognized, since nationally recognized APMs may not necessarily be the best options.

OHIC Response. OHIC agrees with the need for flexibility and the opportunity for innovation, and the Adopted Regulation includes responsive revisions that address this comment.

28. **Section 100(d)(2)(c). Alternative Payment Methodologies.** United comments that the Health Insurer is in the best position to know when to introduce APMs and with whom, not a committee. A Health Insurer cannot be obligated to meet these targets, since willingness of the providers to participate is key.

OHIC Response. OHIC respectfully disagrees with these comments. This Standard does not prohibit Health Insurer innovation and management discretion in the types of APMs to adopt, and does not restrict Health Insurer management discretion in determining which providers are capable of participating in particular types of APM. The need to move away from fee-for-service payment methodologies is critical, however, and the APM Committee, which is established by this Standard, is critical to making progress in this element of health care reform. The APM Committee will include representation from both Health Insurers and providers, among other stakeholders, so that the concerns expressed in these comments can be addressed in the Committee forum.

29. **Section 10(d)(2)(c). Alternative Payment Methodologies.** RIPIN urges OHIC to include consumer advocates during the development of the Alternative Payment Methodology requirements.

OHIC Response. OHIC agrees with this comment, as reflected in the Adopted Regulation.

30. **Section 10(d)(3)(E)(i). Hospital Contracting.** (1) HARI comments that the change in index for measuring permissible hospital rate increases from the CMS Index to CPI-U will further limit hospital rate increases for commercial insurance, which in turn will result in insufficient investments in hospitals and an inability to ensure that delivery system reforms are met. Lifespan opposes using CPI-U for the hospital rate increase limitation because this index is not used by CMS, and because a more

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relevant statewide measure is more accurately captured by using gross state product.
(2) Lifespan also comments that OHIC's process of review for these average rate increases is unclear.

OHIC Response.

(1) To accommodate concerns about moving to a new, more aggressive price index in a short timeframe, the Adopted Regulation adopts a step-down approach over four years to achieve a price increase limitation of no more than changes in CPI-U by 2019. The step down, or phase in approach should allow hospital and other stakeholders more time to adjust to the revised price increase index, and to the need to more effectively restrain hospital cost inflation.

(2) OHIC intends to provide official guidance that Health Insurers and other stakeholders can rely on for identifying the appropriate version of the US All Urban Consumers CPI less food and energy index. OHIC further intends in such guidance to outline the process for implementation of this Standard, in consultation with stakeholders.

31. **Section 10(d)(3)(D)(v) Quality Incentives.** BCBSRI does not support the prohibition of the inclusion of quality incentive payments in the base rate payment in the succeeding year and recommends that the earned quality payment be compounded annually, such that the quality payment earned in the prior year remains at risk and is built upon year over year. BCBSRI further comments that regulation should adopt an overall cap whereby no more than 10% of the hospital's revenue under the contract be earnable for quality unless agreed by the Health Insurer and the hospital.

OHIC Response. OHIC respectfully disagrees with this comment. If quality incentive payments were included in base rate payments and compounded annually, as suggested by the comment, an additional inflationary factor would be created, contrary to, and significantly undermining the purposes of this Standard, and the purposes of the Affordability Standards in general.

32. **Section 10(d)(4)(B) Population-Based Contracts.** (1) HARI comments that the fixed, annual budget growth limitation applicable to population-based contracts may not provide providers adequate flexibility. (2) BCBSRI comments that for the population-based contract annual increase limitation, Health Insurers be allowed to contract using the network trend. BCBSRI suggests using as a budget limitation the "lower of" network trend or CPI-Urban plus 1%. (3) Coastal Medical objects to CPI-U + 1%, as it believes that the annual increase limitation will disadvantage ACO development and that overly stringent regulations could extinguish a promising new movement in health care. Coastal recommends a period of observation before capping ACO total cost of care budget increases.

OHIC Response.

(1) The Adopted Regulation includes an annual stakeholder process to solicit comment and feedback on all yearly targets. This process should be sufficient to

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make adjustments when necessary, without diluting the positive impact of the yearly targets.

(2) OHIC respectfully disagrees with this comment. “Network trend” for health care costs is precisely one of the root causes of the affordability crisis since health care costs have historically increased at a more rapid rate than general inflation. The Adopted Regulation instead uses an accepted index for general inflation against which to measure permissible increases in hospital rate increases, or ACO annual budget growth.

(3) OHIC agrees with some, but not all of the concerns expressed in this comment. OHIC has no desire to impede the development of ACO’s as their development is critical to the implementation of this Standard’s population-based contracting provisions. However, OHIC believes that there needs to be some mechanism to ensure that development of ACO’s, with their enhanced market power, reduce health care cost growth rather than maintain current trends. The Adopted Regulation has revised this part of the Standard, however, to provide for a phase in of the annual budget growth limitation over a four year period.

33. **Section 10(e)(2)(B).** United raises concerns about how the Standards will be enforced should it be “impossible to meet the standards or not commercially reasonable to meet the standards.”

OHIC Response. OHIC respectfully disagrees with this comment. OHIC believes that the enforcement standard contained in the Adopted Regulation⁴² strikes an appropriate balance between the need for enforceability so as to achieve the goals of the Affordability Standard, with the need to consider the context within which non-compliance may occur, and whether it is fair to hold the Health Insurer accountable for non-compliance.

34. **Section 10(f) Data Collection and Evaluation.** (1) BCBSRI comments that all data collection should be through the All-Payer Claims Database (“APCD”). Requiring additional data submission from Health Insurers to OHIC is an unnecessary burden, and an additional administrative expense. (2) United does not intend to collect new or additional data to meet data requests under this section. Proprietary or trade secret information must be kept confidential by OHIC and used only for internal purposes.

OHIC Response.

(1) OHIC agrees with some, but not all of the concerns expressed by this comment. The Adopted Regulation has been revised to clarify that the APCD will be used when possible, but there may be some circumstances where the APCD will not be able to provide the data required to implement the Affordability Standards.

(2) Standard procedures at OHIC keep proprietary or trade secret information confidential, to the extent that the request for confidentiality is reasonable and consistent with the other statutory obligations of OHIC.

⁴² Adopted Regulation Section 10(e)(2)(B)

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35. Section 10(f)(1). Data Collection and Evaluation. The Providence Center comments that data collection and evaluation standards must fully incorporate the integration of behavioral health care with other medical care, and that data collection should include a mechanism for measuring the expansion of integrated care practices and outcomes.

OHIC Response. OHIC agrees with this comment, as reflected in the Adopted Regulation.

Specific Comments - Section 11 Administrative Simplification.

36. Section 11(a). Administrative Simplification. The Rhode Island Parent Information Network comments that consumer and employees should be included on the Administrative Simplification Task Force.

OHIC Response. OHIC agrees with this comment, as reflected in the Adopted Regulation.

37. Section 11(b). Retroactive Terminations. (1) BCBSRI comments that: providers should be required to make an eligibility check in order for the provisions of this section apply; the provisions of this section should not apply if the Health Insurer has not collected premium for the period during which the patient received services; and the provision should not apply to COBRA policy holders. (2) UHC comments that these provisions are inconsistent with UHC's current process, and with procedures applicable to Medicaid plans and Medicare Advantage plans.

OHIC response.

(1) OHIC agrees with some but not all of these comments. A process for provider eligibility requests is included in the Adopted Regulation. The Adopted Regulation contains an exclusion when the Health Insurer verifies that the enrollee is covered by another health insurance plan, including a COBRA plan.

(2) The issue addressed by this subsection is a long-standing one, and a source of considerable tension between Health Insurers and providers that is not in the best interests of the health care system. OHIC believes the Adopted Regulation reflects an appropriate resolution of the problem, and is confident other regulatory agencies will address the problem in due time. OHIC will address any actual conflicts between the regulations of different agencies as needed.

38. Section 11(c). Coordination of benefits. (1) BCBSRI comments that: the regulation should not require the Health Insurer to submit for the Commissioner's approval its COB form and process; the regulation should not require an eligibility look-up section flag; and the regulation should not require a Health Insurer to participate in a centralized coverage registry. (2) The Association of Health Insurance Plans (AHIP) requests that stakeholder comments be solicited before the adoption of a common COB form; and requests that the CAQH process for development of a centralized coverage registry be considered and acceptable alternative to the requirements of this

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subsection. (3) Lifespan comments that the Administrative Simplification provisions should address other administrative burdens imposed by Health Insurers.

OHIC Response.

(1) OHIC believes that these are important provisions for consumers and providers, and that they will not be unduly burdensome for Health Insurers; however, the Adopted Regulation includes a phase-in process for implementation of the eligibility flag system, and clarifies that the eligibility flag system is to be used to signify the most recent information available to the Health Insurer.

(2) OHIC intends to solicit comments from stakeholders before the adoption of a common COB form. OHIC will take into consideration the CAQH registry development process as it proceeds with implementation of this subsection.

(3) The Administrative Simplification Task Force will be engaged in an on-going process. Additional topics can be addressed, as determined by Task Force members.

39. **Section 11(d). Appeals of timely filing denials.** BCBSRI suggests technical revisions to this subsection, requests that the regulation not require the Health Insurer to seek the Commissioner's approval for its appeal checklist, and suggests that some outside limit be placed on the ability of the provider to appeal these types of denials. UHC makes a similar comment on the need for an outside time limit on these types of appeals.

OHIC Response. OHIC agrees with some of the suggestions for technical revisions, and agrees that some outside limit on appeals should be established, as reflected in the Adopted Regulation. The "timely filing" issue has been a long-standing area of concern and dispute, and OHIC believes approval of a checklist process is necessary to implement the new requirements of this subsection.

40. **Section 11(e). Medical Records Management.** (1) BCBSRI suggests that these provisions are not necessary, and that they overlap with other provisions of law. (2) AHIP suggests some coordination between these provisions and HIPAA requirements, and has concerns about the information required to be available on a website to providers whose patient records are requested. (3) UHC comments that it is not feasible for the company to implement the medical records procedures required by this subsection.

OHIC Response.

(1) & (2) OHIC believes that these provisions are needed, and do not conflict with other laws and regulations. The Adopted Regulation clarifies the intent of these provisions, in order to address some of the issues raised by BCBSRI and AHIP. The Adopted Regulation reflects changes in how a Health Insurer will make available to providers the information required by this subsection.

(3) OHIC will entertain a request from UHC under Section 10(e)(1), demonstrating the manner in which UHC's medical records procedures accomplish the purposes of this subsection in an appropriate manner.

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Specific Comments – Section 12 Price Disclosure.

41. **Section 12 (e). Price Disclosure.** Lifespan comments that a standardized method should be used for disclosing hospital rates, or made as consistent as possible, and that price disclosure should include Massachusetts and Connecticut providers.

OHIC Response. OHIC agrees with some but not all of the concerns raised in this comment. Greater standardization in standards for disclosing price information may be useful, but will require additional work and collaboration with stakeholders. The Adopted Regulation clarifies that price disclosure should include all in-network providers, regardless of the location of the provider.

In conclusion, OHIC respectfully disagrees with the all of the general and specific comments of the interested parties, except as noted above, and therefore rejects them.