

Office of the Health Insurance Commissioner
Health Insurers: Affordability Reports Guidance — March 27, 2009

A. Purpose

The purposes of Insurer's Affordability Plan are to

- Make public its efforts to identify and address underlying costs of care in RI;
- Hold health plans accountable for the efficacy of those efforts; and
- Increase alignment and focus across payers in these efforts.

B. Background: Public Guidance (from OHIC Regulation 2)

"A health insurer's strategies to enhance the affordability of its products will be evaluated based on the following:

- i. Whether the health insurer offers a spectrum of product choices to meet consumer needs;
- ii. Whether the health insurer offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself. Such incentives will drive efficiency in the following areas:
 - A. *Creating a focus on primary care, prevention and wellness;*
 - B. *Establishing active management procedures for the chronically ill population;*
 - C. *Encouraging use of the least cost, most appropriate settings; and*
 - D. *Promoting use of evidence based, quality care;*
- iii. Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services;²
- iv. Whether the insurer supports product offerings with simple and cost effective administrative processes for providers and consumers;
- v. Whether the insurer addresses consumer need for cost information through
 - (A) Increasing the availability of provider cost information; and
 - (B) Promoting public conversation on trade-offs and cost effects of medical choices."

¹These four areas are considered OHIC's "Affordability Principles"

²Health Plan implementation strategies may include — provider payment reform, provider measurement and feedback, benefit design, consumer education, delivery system change initiative, program management, administrative simplification etc.

C. Current Situation: Projected Trend rates*

Expense Category	Share of Total Medical Expense (%)	Price Trend (%)	Utilization Trend (%)	Overall Trend 2009 to 2010 (%)	Prior Year (2008-2009)
Inpatient Hospital	16.2%	7.4%	1.3%	8.8%	N/A
Outpatient Hospital	24.9%	7.5%	4.2%	12.0%	N/A
Pharmacy	19.3%	7.3%	2.6%	10.1%	N/A
Primary Care Physician	6.9%	6.7%	1.3%	8.1%	N/A
Other Physician/other	32.7%	5.8%	2.7%	8.7%	N/A

* These figures should duplicate those in your plan's rate factor filing.

D. System Affordability Strategy

1. List and comment on the three most significant drivers affecting medical costs that you see in the Rhode Island market in the next five years.

In Rhode Island, the population of individuals 65+ years is expected to grow at a faster rate than the overall population. This change in the state's overall demographics should be considered an accelerant of those issues noted below.

- New technologies, in particular biologics and genetic/other lab testing

New technologies are emerging at a rapid rate in areas such as anti-tumor agents, arthritis treatments, autoimmune disease management, etc. with many more uses for biologics in the research and development pipeline. These new treatments have great potential to manage disease but are expensive to produce and will drive increased medical cost.

The use of genetic testing has grown rapidly in recent years while the evidence to support appropriate use of the tests and the appropriate clinical response to the results has not kept pace. This phenomenon may result in increased cost both from over or inappropriate use of the tests as well as from subsequent unnecessary interventions.

- The influence of lifestyle factors on overall health and healthcare costs

Approximately 50% of all healthcare costs are related to individuals' behavior relative to managing their personal health risks. Some key health factors that relate directly to individuals' behavior include weight management, tobacco usage, and physical exercise. Additionally, individuals' behavior is critical to the management of diseases that are influenced by lifestyle factors such as diabetes, hypertension, and emphysema. Additionally, many people are electing to manage these issues with medical interventions such as bariatric surgery or medication to assist with tobacco cessation.

- Increase in elective surgical procedures

Elective surgical procedure rates are increasing. In particular, elective surgeries for musculoskeletal conditions are rising rapidly and procedures are being performed earlier in the course of a patient's symptoms. Additionally, many procedures are now performed more than once in a patient's life or a partial procedure is performed to replace previously implanted devices. Consumer demand for these procedures has grown as individuals seek to, for example, maintain an activity level that is compromised by joint pain.

2. Briefly (in less than 1 page), what is your company's strategy — given these cost drivers - to improve the overall affordability of health care in RI in the next five years?

Tufts Health Plan has a three-pronged approach to managing medical costs. Tufts Health Plan has numerous initiatives in the area of improving efficiency in the delivery system, promoting adherence to evidence based medicine, and facilitating and supporting member behavior change. Effectiveness in achieving strong outcomes in each of those areas is enabled by robust use of data and technology and by providing incentives for both providers and members to align around the appropriate use of health services. All of Tufts Health Plan's efforts are approached with an unyielding focus on promoting quality care for our members.

Delivery System Efficiency: Tufts Health Plan's efforts in this area are aimed at ensuring unnecessary costs are eliminated. Initiatives in this area include inpatient case management, often supported by on-site nurses, overseeing requirements for delivering care in the appropriate setting, and education and programs targeted at encouraging use of generic drugs when available and appropriate.

Adherence to Evidence Based Medicine: Tufts Health Plan systematically analyzes our claims experience to identify patterns that indicate an opportunity for consistent delivery of care. Where we find unexplained provider variation in utilization patterns or an unexplained overall increase in the frequency of a procedure, we develop programs such as prior authorizations for particular services to ensure that providers are utilizing evidence based standards of care. Tufts Health Plan also develops programs to support providers and improve care for our members, such as discharge planning, case management, readmission prevention, and identifying gaps in care.

Member Behavior Change: Tufts Health Plan has a comprehensive approach to educating and supporting members to live healthy lifestyles and make optimal decisions regarding their health care. Tufts Health Plan has robust disease management programs for members with chronic conditions. Additionally, Tufts Health Plan recently launched a redesigned member portal on our web site that makes information and tools readily available to members, including shared decision making videos, provider cost and quality comparisons, a treatment cost estimator, health trackers for key vital statistics, and a personal health assessment. Tufts Health Plan also works closely with our employer groups to develop wellness and health promotion programs for their employees. Additionally, if a potential gap in a member's care is identified, we notify both the provider and the member, thus enabling the member to take an active role in managing health risks.

Enablers: The above efforts are supported by analysis of medical and pharmacy claims as well as detailed review of evidence-based standards as established by nationally recognized medical associations. In addition, Tufts Health Plan works with providers to utilize contract structures that do not just pay on a fee-for-service basis, but include incentives to increase quality as well as provide the appropriate level of care to members, so as to attempt to keep health care coverage affordable.

3. What is your resulting anticipated overall annual trend for the next three years:
 - a) Baseline trend: Assuming consistent membership + benefit mix, with no new programs. **11%**
 - b) Baseline trend: After adjusting for membership/benefit mix **9%**
 - c) Adjusted Trend: Adjusted for impact of affordability strategy outlined in your response to question number two. **7.7%**

E. Rate Factor Standards for Medical Cost Improvement

Specific Health Plan Affordability Priorities and Standards have been developed by OHIC with the guidance of the Health Insurance Advisory Council for commercial insurers doing business in Rhode Island.

To show adherence with their statutory obligation to engage in "policies that advance the welfare of the public through overall efficiency, improved health care quality and appropriate access", in conjunction with their annual filing of rate factors for small and large group commercial insurance products, health insurers must demonstrate that they meet standards for each of the four specific system affordability priorities listed below (the details of which are provided in an attachment to this guidance, excerpted from the document: "System Affordability Priorities and Standards for Health Insurers in Rhode Island" available on the OHIC website.)

System Affordability Priorities:³

Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

- I. Expand and improve the primary care infrastructure in the state- with limitations on ability to pass on in premiums)

In order to meet the proposed standard, we are required to demonstrate that our spending on primary care shall reach 6.9% of total medical expense for the 12 month period starting January 2010. In addition, this ratio shall increase by one percentage point in each of the subsequent years through 2014.

We intend to submit a plan in September 2009 that describes our specific approaches to prioritizing primary care spending, which will be in a manner that does not contribute to increase in premiums.

As a new market entrant, Tufts Health Plan has a number of unique factors that we believe should be reasonably considered:

- **Volatility of performance due to small volume.** As of April, 2009 Tufts Health Plan's share of the Commercial market in RI is less than 5%. Given the small volume, our performance is naturally less stable, which makes projection and measurement considerably challenging.
- **Lack of data on baseline performance.** Our 2010 target of 6.9% was developed based on current market average, which may or may not align with Tufts Health Plan's actual spending pattern. The earliest time we can assess the target based on actuarial data with minimum credibility is after the assessment of 2009 utilization. As a result, our ability to plan initiatives based on required effort is limited.
- **Small proportion of the network open for 2010 contracting.** In order to enable our 2009 market entry, the vast majority of our multi-year provider contracts started in 2009, with commitments through 2010 or beyond. Therefore, we have low flexibility to influence network-wide primary care spending ratio in 2010 through rate negotiation.
- **Limited opportunity to implement creative contracting structures.** We believe the more preferable approach to increasing primary care spending is to incorporate provider incentive (pay-for-performance) to promote primary care, vs. direct shift of fee schedules. Tufts Health Plan's ability to implement performance-based incentive programs in the near term is restricted by two factors:

- Pay-for-performance programs are primarily suitable for HMO or other PCP-driven product types. The vast majority of our RI membership is PPO, which makes it difficult for us to design and implement pay-for-performance programs
- Pay-for-performance programs require sufficient volume to be viable with providers. Tufts Health Plan's volume is substantially below a reasonable level to consider such programs.

As part of OHIC's oversight on carriers' efforts towards the primary care spending targets, we propose a six-month interim review for the first half of 2010. The review shall take place in October, 2010, with the following objectives:

- Tufts Health Plan will report to OHIC its primary care spending ratio during the January – June 2010 period
 - The report will include an assessment of preliminary impact of initiatives through comparison with 2009 performance.
- Tufts Health Plan will provide an updated projection of whether the original 2010 target will be achieved
 - Will take into account relevant factors that may influence the projection (e.g., seasonality, program ramp up, significant change in mix of population).
- In the event that based on the interim review, Tufts Health Plan has compelling reasons to believe that the original target for 2010 is not appropriate, and OHIC agrees with this perspective based on one or more factors unique to Tufts Health Plan, OHIC and Tufts Health Plan will discuss an adjustment to the targets that lead to the longer-term primary care spending goal through 2014, including milestones that require appropriately defined efforts from Tufts Health Plan.

II. Spread Adoption of the Chronic Care Model-Style Medical Home

Tufts Health Plan agrees to participate in the all payer medical home collaborative in Rhode Island. Specifically, we will support the statewide effort to expand the RI Chronic Care Sustainability Initiative (CSI-RI) during the period July 2009 through June 2010, which includes the goal of adding 15 physician FTEs on top of the current 28.

Tufts Health Plan's contribution to the above initiative will be in the following areas:

Based on our understanding of the proposed standard, during the period July 2009 through June 2010, we will share the program costs of qualified medical home pilot sites at \$3mpm, with the member-month calculated based on the actual enrollment of Tufts Health Plan members in these qualified medical home sites during the above time period, as appropriately determined by the attribution logic developed by OHIC and consented by the carriers

Also based on the proposed standard, if Tufts Health Plan members that participate in the medical home initiative (determined by the above attribution logic) exceed 200, we will agree to contribute to the funding of nurse case managers retained by these qualified medical home sites, in a manner that reasonably reflects Tufts Health Plan's share of the market and the medical home initiative

Tufts Health Plan currently has representatives on the CSI-RI steering committee, and we will continue this participation going forward.

III. Standardize EMR incentives

Tufts Health Plan agrees to participate in the statewide effort to encourage EMR adoption by implementing a physician incentive program to be effective January 1st, 2010. The program will include the following required components:

- Incentive payments (specified below) to physician practices that adopt EMR infrastructure with certification by the Commission for Healthcare Information Technology, and registry functionality to promote patient tracking in the manner prescribed by NCQA PPC-PCMH standards for a medical home.
- Initial payment of \$500 per physician, up to a practice maximum of \$1,500 to subsidize the cost of EMR acquisition. This amount, based on our understanding, is proposed by OHIC according to reasonable representation of Tufts Health Plan's share of the market.
- Additional support for the cost of EMR implementation totaling in value at least 3% greater than the Tufts Health Plan standard network fee schedule in 2010.
- An annual cap for the number of physicians enrolled in the incentive program will be determined by Tufts Health Plan prior to January 1st, 2010. The cap will be no less than 200 for 2010, and compliant with OHIC requirement going forward.

In March, 2010, Tufts Health Plan will demonstrate to OHIC that we have implemented the physician incentive program for EMR adoption that incorporates the key components above. And as part of the rate factor filing we will include data on payments as a result of this program.

IV. Work toward comprehensive payment reform across the delivery system

Tufts Health Plan has in the past, and will continue to support the concept of payment reform to address the weaknesses of the fee-for-service payment model. In response to OHIC's proposed standards, we commit to the following steps around participation in the process to explore, assess, recommend and adopt reforms:

- Be a member of the stakeholder body to be convened by OHIC in coordination with other state government entities. Representatives of our Actuarial, Clinical Services and Network Contracting functions will be regular participants in the ongoing discussions.
- Agree to provide non-competitive information to the body to assist it in its deliberations, to the extent that the information is relevant and adding value to the questions to be resolved.

Tufts Health Plan is open to evaluating opportunities to structure and test alternative payment models in collaboration with provider entities and other constituents.

1. Please confirm that you have read and understand the priorities and standards, and your specific obligations as described in "System Affordability Priorities and Standards for Health Insurers in Rhode Island"⁴.

Tufts Health Plan hereby confirms that we have read and understand the priorities and standards as described in "System Affordability Priorities and Standards for Health Insurers in Rhode Island".

2. Please submit to OHIC your initial recommendations for an OHIC oversight process that would address any concerns you might have for meeting the standards. These will be taken under advisement.

We anticipate that OHIC will convene a series of discussions in the coming months which will allow the parties to ask more detailed questions and articulate more definitive processes. Accordingly, we expect to gain more clarity overtime around the steps that we will make to deliver our commitments.

³Subject to final modification and approval at the April 21, 2009 Health Insurance Advisory Council Meeting.

⁴ Subject to final modification and approval at the April 21, 2009 Health Insurance Advisory Council Meeting.

F. Company Specific System Affordability Initiatives

Please list the five most significant (in term of overall financial impact) initiatives⁵ your company is undertaking to improve the affordability of healthcare in Rhode Island in the next three years.

Initiative	OHIC Affordability Principles Targeted	Description	Implementation Strategies Employed	Approximate Savings Return
Enhanced cooperation with acute care institutions to improve the efficiency of inpatient care	Employs provider payment strategies that address the underlying cost of health care by encouraging use of the least cost, most appropriate setting	Tufts Health Plan will support the efficient use of inpatient resources by working with acute care institutions to define the appropriate level of care and to assist in the transition of members between levels of care.	<ol style="list-style-type: none"> 1) Assisting hospitals with timely classification of observation vs. inpatient services 2) Providing hospitals with an expected length of stay for each admission 3) Reimburse for extended days based on clinical criteria 4) Assist with transition to home of other level of care 5) Expand outreach to members discharged to home 	2-3% of inpatient medical/surgical costs
Require use of evidence-based medicine where such evidence is available	Employs provider payment strategies that address the underlying cost of health care by promoting use of evidence based, quality care	Tufts Health Plan systematically identifies unexplained variation in medical practice. If unexplained variation exists in combination with evidence based standards of practice, Tufts Health Plan implements programs to support evidence-based decision making.	<p>Prior authorization programs are an essential strategy for Tufts Health Plan. Due to the dynamic nature of emerging medical evidence and new procedures, Tufts Health Plan frequently introduces new prior authorization programs and re-evaluates its existing programs.</p> <p>Additionally, Tufts Health Plan utilizes several tools in the management of new technologies. These tools include:</p> <ul style="list-style-type: none"> • Prior authorization to match service requests with medical evidence (example: genetic testing) • New-to-market pharmaceutical program in which new drugs or biologics are evaluated for efficacy and safety prior to being approved for the Tufts Health Plan formulary 	Savings varies depending on the specific program. Example: Hysterectomy PA program resulted in a ~27% decrease in utilization.

<p>Comprehensive member-centric disease and case management</p>	<p>Address the underlying cost of health care with active management procedures for the chronically ill population</p>	<p>Tufts Health Plan provides its members with a comprehensive suite of disease management programs as well as case management services for those members with complex health issues unrelated to a chronic condition.</p>	<p>Tufts Health Plan's disease management program includes the following conditions:</p> <ul style="list-style-type: none"> •Diabetes •Heart Failure •COPD •CAD •Asthma •Back Pain •Osteoarthritis •Chronic and End-stage Renal Disease. <p>Tufts Health Plan also provides case management services to its members with complex medical issues through our Tufts Health Priority Care program in which RNs work directly with members over the phone to understand their medical issues, focus on improved self care, navigating the health care system, and communicating effectively with direct care providers.</p> <p>Tufts Health Plan continually evaluates the efficacy of its programs and makes changes to optimize results.</p>	<p>Specific savings varies by program. Program ROIs generally range from 2:1 to 4:1</p> <p>Tufts Health Priority Care has decreased inpatient days in the managed population by 26%.</p>
<p>Enhanced Tufts Health Plan web site designed to engage members in improving their self management of their health and in making good healthcare choices</p>	<p>Promote the dissemination of information, increase consumer access to healthcare information and cost information</p>	<p>Tufts Health Plan has undertaken a multi-year plan to more fully engage our members in their health and healthcare via the Tufts Health Plan web site.</p>	<p>The Tufts Health Plan web site currently offers members:</p> <ul style="list-style-type: none"> • Treatment Cost Estimator • Personal Health Assessment • Hospital Cost and Quality Comparison Tool • Blue Ribbon PCP Designation • Healthwise Health Content • Member Health Communities • Shared Decision Making Videos • Health Tracker Tools 	<p>Improved self-management of health risk factors can have a significant impact on cost. Estimates are that an individual's health care costs can be reduced by as much as 60% with the</p>

			Tufts Health Plan’s multi-year plan includes further enhancements to web-based tools as well as increased personalization of health reminders, health content and shared decision making. Additionally, Tufts Health Plan will evaluate new approaches for combining health coaching with shared decision making such as our Pre-bariatric surgery program.	elimination of one serious risk factor. Tufts Health Plan will measure the impact of our Member Engagement programs once more outcome data is available.
Expand the employer group / health plan partnership to improve employee involvement in their health choices and health improvement	Promote the dissemination of information, increase consumer access to healthcare information and cost information	Consult with employer groups around plan designs that increase affordability and engage employees in appropriate use of healthcare services	<ul style="list-style-type: none"> • Engage employer groups and their employees in activities such as completion of a PHA to identify health risks and mitigation strategies. • Promote plan designs such as Tufts Health Plan’s Choice Copay that incent members to use more efficient providers. • Partner with employers to develop multi-year worksite health and wellness programs 	As above

⁵ Initiatives are specific programs, projects, sets of actions, priorities etc. Financial impact is based on internal assessment.

⁶ Proprietary information: Because the affordability of health care encompasses many stakeholders and improving it involves changing basic elements of how medical care is used, delivered and paid for, these efforts are essentially public or collective in nature. However, as private entities, health plans compete in a market and have proprietary information to maintain a competitive advantage. Affordability Reports should not disclose proprietary information.

- What is proprietary: trade secrets; efforts which increase member, consumer or provider loyalty, unless they impose or shift costs to the public.
- What is public: efforts to improve performance of the delivery system; administrative initiatives; efforts to improve public health; collaborations with other stakeholders.

⁷ E.g.: provider payment reform, provider measurement and feedback, benefit design, consumer education and incentives, delivery system change initiatives, program management (e.g. care management, disease management), administrative simplification etc.

Appendix A: Detailed Affordability Standards — March 2009

These proposed standards, developed with the guidance of the Health Insurance Advisory Council, would be for commercial insurers doing business in Rhode Island. To show adherence with their statutory obligation to engage in "policies that advance the welfare of the public through overall efficiency, improved health care quality and appropriate access", in conjunction with their annual filing of rate factors for small and large group commercial insurance products, health insurers would have to demonstrate that they meet the following standards.

Standard #1: Primary Care Spend

1. March 2009: The insurer shall commit in writing that the rates that the insurer will propose to charge to small and large employers in Rhode Island for 2010 shall demonstrate that the proportion of the insurer's medical expense to be allocated to primary care for the 12 months starting January 1, 2010 shall be one percentage point higher (e.g., from 5% to 6% of medical expense) than reflected in actual spending for the twelve months starting January 1, 2008.

This proportion shall continue to increase by one percentage point per year, for five years.

- a) Tufts Health Plan, as a new entrant, shall be required to achieve a 6.9% primary care spend (one percentage point higher than the current market average), by January 1, 2010.
 - b) Resulting primary care expense allocation shall be reported every six months, starting in February, 2009, in accordance with the definition provided by OHIC.
2. September 2009: The insurer must submit a plan to OHIC that demonstrates how the increase is to be achieved, and that it will be accomplished in a manner that does not contribute to the increase of premiums. That is, the insurer may fund the increase by:
 - a. increasing primary care payments, while either decreasing payments, not increasing payments, or funding smaller increases than what the insurer has historically awarded to other service providers, and/or
 - b. increasing volume of primary care delivery and decreasing volume of non-primary care services.
 3. March 2010: Rate factors that the insurer proposes to use for rates to charge to small and large employers in Rhode Island for the 12 months beginning July 1, 2010 shall reflect the new allocation of payments to primary care beginning Jan 1, 2010 and an additional one point higher allocation of payments to primary care beginning Jan 1, 2011 as compared to actual spending for the twelve months starting January 1, 2008.

4. March 2011:
 - a. The insurer must demonstrate whether the required increase in primary care expenses projected for the 12-month period starting Jan 1, 2010 was achieved, and if so, exactly how it was accomplished in a manner that did not contribute to a larger increase in medical expense than would have otherwise occurred.
 - b. Rates factors that the insurer proposes to use for rates to charge to small and large employers in RI for the twelve months starting July 1, 2011 shall demonstrate that the proportion of medical expense to be allocated to primary care shall be an additional one percentage point higher for the twelve months starting January 1, 2012 than reflected in actual spending for the twelve months starting January 1, 2011.
5. OHIC may, at its discretion, require a review of the insurer's calculations by an independent auditor.

Standard # 2: Chronic Care Model-style Medical Home

1. March 2009: The insurer shall commit in writing to supporting an expansion of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) during the period July 2009 through June 2010.
 - a. The expansion shall entail an increase of at least 15 PCP FTEs⁸ from the current 28 FTE level, including the addition of new practices beyond the initial 5 CSI-RI practice participants.
 - b. The expansion shall include the Chronic Care Model-based elements that were included in the initial CSI-RI implementation, including training in the Chronic Care Model, and funding of a nurse case manager, among other CSI-RI elements.
2. March 2010:
 - a. The insurer must demonstrate that the successful expansion of CSI-RI to at least 15 new physician FTEs from new practices occurred during the 12 month period starting July 2009
 - b. The insurer shall commit in writing to supporting an additional expansion of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) during the period July 2010 through June 2011, adhering to the same parameters as for the 2009-2010 expansion.

⁸ The addition of 15 physician FTEs will increase the patients affected by the program, as a percentage of the total state population from 2.38%, to 3.69%, the latter being the national multi-payer medical home benchmark level that PA will achieve in 2009.

Standard #3: Mandated EMR Incentive

1. March 2009: The insurer shall commit in writing to the implementation of a physician (primary care and/or specialty care) EMR adoption incentive on or before January 2010, that meets the following standards:
 - a. The incentive must be applied only to practice adoption of EMRs with:
 - i. certification by the Commission for Healthcare Information Technology (CCHITsm)⁹, and
 - ii. registry functionality to promote patient tracking in the manner prescribed by NCQA PPC-PCMH standards for a medical home.
 - b. The incentive must be equivalent in value to one or more of the following thresholds¹⁰:
 - i. initial payment per physician to subsidize the cost of EMR acquisition, adjusted for carrier market share as follows¹¹; and
 1. BC: \$5,000 or more, up to practice maximum of \$15,000
 2. United: \$2,500 or more, up to practice maximum of \$7,500
 3. TuftsHP: \$750 or more, up to a practice maximum of \$2,250
 - ii. support for the cost of EMR implementation and operation in the form of pay-for-participation payments equal to \$.60 PMPM or in increased fees, totaling in value at least 3% greater than the insurer's standard fee schedule.
2. March 2010: The insurer shall demonstrate the implementation of a physician (primary care and/or specialty care) EMR adoption incentive that meets the standards defined above. As part of its rate factor filing the insurer should submit data on the payments made as part of the incentive program.

⁹ CCHIT certification standards for Ambulatory Electronic Health Records can be accessed at www.cchit.org/certify/ambulatory/index.asp.

¹⁰ These standards are informed by national analysis and practices by payers in Rhode Island and elsewhere in the U.S.

¹¹ Based on per physician EMR adoption cost of \$33,000, a target of 25% overall subsidy, and market shares of 60/30/10 respectively.

Standard # 4: Fundamental Payment Reform

1. March 2009: The insurer shall commit in writing to participate in a state-facilitated process to explore, assess, recommend and adopt reforms to health care service payment in Rhode Island. Participation shall include:
 - a. active engagement as a member of the stakeholder body to be convened by OHIC in coordination with other state governmental entities, and
 - b. provision of non-competitive information to the body to assist it in its deliberations.
2. Should the body have convened during 2009, the insurer must have demonstrated participation consistent with the requirements of #1 above.
3. March, 2010: To be decided