RHODE ISLAND GOVERNMENT REGISTER
ADVANCE NOTICE OF PROPOSED RULEMAKING

DEPARTMENT OF BUSINESS REGULATION (INCLUDES THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER)

Title of Rule: Powers and Duties of the Office of the Health Insurance Commissioner

Rule Identifier: 230-RICR-20-30-4

Rulemaking Action: Advance Notice of Proposed Rulemaking

Important Dates:
Date of Public Notice: 05/09/2019
End of Public Comment: 05/30/2019

Authority for this Rulemaking:
R.I. Gen. Laws § 42-14.5-1 et seq., 42-14-5, and 42-14-17.

Summary of Rulemaking Action:
The Office of the Health Insurance Commissioner (OHIC) is seeking input on the future direction of the Affordability Standards, 230-RICR-20-30-4.10. The Affordability Standards are designed to improve the affordability of health insurance by ensuring that health insurance companies regulated by OHIC are taking necessary action to improve the efficiency and quality of health care in the state. As part of its statutory powers and duties (RIGL 42-14.5 et seq.), OHIC has promulgated several requirements for insurers which embrace increased investments in primary care and practice transformation, expanded use of alternative payment models, and regulatory guardrails on provider contracting which seek to limit cost inflation. OHIC is soliciting input from interested parties on the future direction of the Affordability Standards. In offering input, interested parties are encouraged to bear in mind the following health policy objectives:

1. Improved affordability of health insurance.

2. Improved health care quality, inclusive of patient safety, effectiveness, efficiency, timeliness of care, patient-centeredness, and equity.

3. Better integration of physical and behavioral health care.

4. Reduced administrative burden and improved clinician wellbeing.

The attachment *Affordability Standards Potential Modifications 2019 5-8* compiles a set of potential modifications to the Affordability Standards that are under serious

consideration by OHIC. In addition to these potential modifications, stakeholders are welcomed to propose other ideas for consideration.

BACKGROUND

The Affordability Standards were developed in 2009-10 by the Office of the Health Insurance Commissioner (OHIC) in consultation with its legislatively created Health Insurance Advisory Council. The Affordability Standards are a core component of OHIC's efforts to meet its statutory mission to improve the health care system, to protect consumers, and to improve the affordability of health insurance. As part of the annual rate review process for health insurance premiums, health insurers are required to prove that the rates filed for approval by OHIC are consistent with the proper conduct of the health insurer's business and the public interest. Given the public's interest in affordable health insurance, OHIC developed the Affordability Standards to systematize regulatory requirements for insurers to demonstrate their efforts to improve affordability and health care quality.

Since 2010, the Affordability Standards have been modified from time to time. The present iteration of Affordability Standards comprises the following policies:

Standard One: Primary Care Spend Obligation

Requires insurers to ensure that total medical payments made to primary care are at least 10.7 percent of annual medical spend, with 9.7 percent for Direct Primary Care Expenses. Indirect Primary Care Expenses must include at least a proportionate share for administrative expenses incurred to support and strengthen the capacity of a primary care practice to function as a medical home and to successfully manage risk-bearing contracts, and to support the health information exchange.

Standard Two: Primary Care Practice Transformation

Requires that by 2019, 80 percent of insurers' contracted primary care providers practice in Patient-Centered Medical Homes as designated by OHIC.

Standard Three: Payment Reform

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

1. **Population-based Contracting**: Requires that by the end of 2015, at least 30 percent of insured covered lives are attributed to a Population-Based Contract that is a Shared Savings Contract, a Risk Sharing Contract, or a Global Capitation Contract; and by the end of 2016, at least 45 percent are attributed

to such arrangements with at least 10% of covered lives attributed to a Risk-Sharing Contract or Global Capitation Contract.

2. **Alternative Payment Methodologies:** Requires insurers annually to increase their use of nationally recognized, alternative payment methodologies for hospital, medical and surgical, and primary care services.
3. **Measure Alignment:** Requires insurers to use the OHIC Aligned Measure Sets for primary care, hospital, and Accountable Care Organization contracts.
4. **Hospital Contracts:**
    a. **Unit of Service Payments:** Insurers must use unit-of-service payment methodologies for both inpatient and outpatient services that provide incentives for efficient use of health services.
    b. **Quality Incentive Program:** Insurers must include payment for attaining or exceeding mutually agreed to, sufficiently challenging, performance levels for all Core measures within the Aligned Measure Set for hospitals.
    c. **Limit Rate Increases:** Insurers must limit annual rate increases, including quality incentive payments, to the U.S. All Urban Consumer All Items Less Food and Energy CPI percentage increase + 1%.
    d. **Administrative Efficiencies:** Insurers must include terms that improve greater administrative efficiencies.
    e. **Transparency:** Insurers must include terms that relinquish the right of either party to contest the public release of any or all of these five specific terms by state officials or the participating parties to the agreement.

Population-based Contracts: Insurers must limit budgets for Population-Based Contracts to the US All Urban Consumer All Items Less Food and Energy CPI + 3.5% in 2015, +3% in 2016, + 2.5% in 2017, + 2.0% in 2018, and + 1.5% after 2018.

Additional Information and Comments:
All interested parties are invited to request additional information or submit written or oral comments concerning the proposed amendment until May 30, 2019 by contacting the appropriate party at the address listed below:

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