OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

State of Rhode Island Office of the Health Insurance Commissioner
Affordability Standards Revisions – Summary
November 5, 2014

Between 2001 and 2003, national health care spending grew, on average, by 8.8% per year. Recent data indicates that between 2008 and 2012, national health care spending grew, on average, by 4.2% per year. This growth slowdown has largely been attributed to economic factors such as a more depressed economy and to the shifting of more costs to insured individuals and families.[1] As the economy continues to recover, the healthcare spending growth rate will likely increase and health insurance premiums will continue to rise at a faster rate than wages and the cost of living. To sustain a slower growth rate than in previous years, the health care system will need to continue to move towards new modes of delivery and payment methods that reward providers for more efficient, higher quality care, rather than paying providers for the volume of services they deliver.

In 2004, the Rhode Island State Legislature created the Office of the Health Insurance Commissioner (OHIC) to[2]:

- Guard the solvency of health insurers;
- Protect the interests of consumers;
- Encourage the fair treatment of providers;
- Encourage policies and developments that 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.

OHIC uses its annual health insurance premium form and rate review process to comprehensively review the factors that cause health insurance premiums to increase, including examining medical expense trends (e.g., hospital inpatient, hospital outpatient, and pharmacy trends) to ensure that they are appropriate. OHIC then approves, modifies, or rejects an insurer's proposed insurance premium rate increase based on an actuarial review of these factors. OHIC's form and rate review process is conducted in the context of a greater effort to reduce the cost of healthcare coverage since medical trend is a key driver of health insurance premiums and health insurance spending. To support this mission of reducing cost to consumers, OHIC first enacted

[1] http://kff.org/health-reform/press-release/study-finds-recent-slowdown-in-health-spending-growth-mostly-tied-to-the-economy/
[2] http://www.ohic.ri.gov/documents/Insurers/Regulations/Regulation%202%20OHIC%20Purposes/Link%20to%20Purposes%20Statute.htm

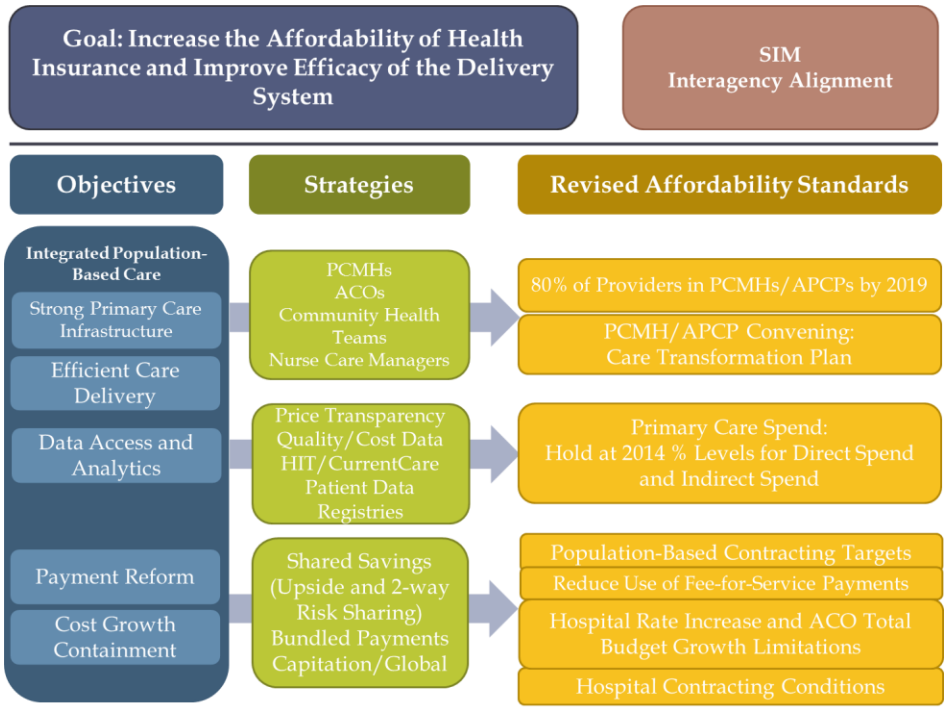
the Affordability Standards in 2010 with the aim of strengthening the state's primary care infrastructure, increasing efforts to integrate care (e.g. the State's patient-centered medical home initiative), and dampening the growth in rates insurers pay hospitals for services. The Standards in their current form are as follows:

- Primary Care Spend: Health insurers must increase the percentage of total medical payments that are made to primary care clinicians by 1% per year and increase funding directed to non-fee-for-service (FFS) activities by 5% percentage points per year.
- Patient-Centered Medical Home: Health insurers are required to support the Chronic Care Sustainability Initiative and can support their own proprietary medical homes as part of the primary care spend requirement.
- CurrentCare: Health insurers must support CurrentCare as part of the primary care spend requirement.
- Hospital Contracting Conditions: Health insurers must:
    - Limit the annual hospital rate increases to a CMS benchmark;
    - Promote adoption of non-FFS payment methodologies, (e.g., DRG, APC, and case rates);
    - Include quality performance measures as a component of the payment methodology;
    - Include terms that define the parties' mutual obligations for greater administrative efficiencies;
    - Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO); and
    - Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

In August 2013, OHIC completed an evaluation of the effectiveness and appropriateness of the Affordability Standards that included stakeholder interviews to evaluate the efficacy of each Standard and recommended modifications to the current Standards. The evaluation found that the Standards have increased primary care infrastructure in the State, accelerated patient-centered medical home transformation efforts, and slowed the rate of hospital cost increases. Throughout late 2013 and into the fall of 2014, OHIC worked with the health insurance carriers and other stakeholders to refine these modifications and to draft revised regulations around these changes.

With this next round of revisions, OHIC is encouraging initiatives that result in more integrated population-based care, where provider organizations are accountable for the total cost and quality of care for a defined population, in order to achieve the goals of increased affordability and improved efficacy of the delivery system. Population-based care is built upon a strong

primary care infrastructure, delivery models that promote efficient care delivery, access to data and analytic capacity, and payment reform, in order to improve quality of care and contain cost increases. The following diagram depicts the manner in which the Affordability Standards support the broader system redesign goals, strategies and objectives.



More specifically, OHIC's revised Affordability Standards addresses these five objectives through the following modifications to Regulation 2:

- Primary Care Spend: OHIC will be conducting an in-depth benchmarking study to more comprehensively understand primary care spend across the country, including data from high-performing systems. While this study is being conducted, insurers are required to direct at least 10.7% of total medical payments towards primary care spend, direct at least 9.7% of total medical payments to "Direct Primary Care Spend", defined as payment that directly benefits primary care practices, and direct at least 1% of total medical payments to "Indirect Primary Care Spend", defined as payment that strengthens the capacity of primary care practices to function as patient-centered medical homes (PCMHs) and to manage care under risk-bearing contracts, but which does not qualify as Direct Primary Care spending.
    - Indirect primary care spending will include administrative support for the Chronic Care Sustainability Initiative (CSI-RI) and support for CurrentCare, RI's health information exchange.

  - Insurers may not fall below current (CY14) levels of support and the 10.7% requirement will hold in place gains made to date under existing Affordability Standards. Creating direct and indirect primary care categories assures that primary care spending goes towards supporting primary care and developing capacity to manage care under payment reform models.

- Primary Care Practice Transformation: OHIC is requiring health insurers to take actions such that by December 31, 2019 80% of contracted primary care practices are functioning as PCMHs. Additionally, health insurers shall provide contractual incentives and disincentives for practices to transform into PCMHs.
  - In order to achieve the 80% target, the Commissioner shall convene a Care Transformation Advisory Committee by February 1, 2015 and January 1 of each year thereafter, composed of employers, consumers, providers and health insurers, which will be charged with developing and submitting to the Commissioner by May 1 annually a transformation plan to achieve the 80% goal, including:
    - Annual targets,
    - Activities and financial support by insurers to achieve the targets, and
    - Alignment on performance measurement, reporting and data exchange between providers and health insurers
  - A PCMH can be defined as a primary care practice endorsed by CSI-RI, recognized by a national accreditation body, or an advanced primary care practice program established by contract between an insurer and a primary care practice or an integrated system of care. OHIC sees PCMHs as a key step along the spectrum to achieve population-based care and recognizes the need to address the challenges with engaging and supporting the many small independent primary care practices that are not yet PCMHs.
- Payment Reform:
  - Population-Based Contracting Targets: Although integrated systems of care, such as Accountable Care Organizations, are emerging in Rhode Island within large health care systems, they currently only provide care to less than 20% of covered lives. In order to derive the benefit of population-based contracting, OHIC is setting targets to promote population-based contracting, while recognizing that entities must be ready to accept downside risk. Insurers will determine whether each provider organization has the operational and financial capacity to enter into such agreements.
    - By the end of 2015: at least 30% of insured covered lives shall be subject to population-based contracts with upside risk;

- By the end of 2016: at least 45% of insured covered lives shall be subject to population-based contracts with upside risk and 10% with upside and down-side risk; and
- By the end of 2017: at least 60% of insured covered lives shall be subject to population-based contracts with upside risk and 20% with upside and down-side risk.

- Alternative Payment Methodologies: Health insurers are required to annually increase use of alternative payment methodologies that mitigate fee-for-service volume incentives for hospital services, medical and surgical specialty services, and primary care services. Reducing FFS as a payment methodology will mitigate volume incentives which increase the overall cost of care. Replacing FFS payments with alternative payment methodologies will provide incentives for higher quality and more efficient health care services and improved population health. To accomplish this goal, the Commissioner will convene an Alternative Payment Advisory Committee which will be charged with submitting a schedule for increasing the percentage of hospital, primary care and other medical/surgical expenses paid using non-FFS methodologies.
- Hospital Contracting Conditions
  - In their hospital contracts, health insurers must promote affordability by limiting hospital annual rate increases, including quality incentive payments, to the U.S. CPI-Urban less Food and Energy for the Northeast Region and assuring that at least 50% of annual rate increases must be earned through performance incentives.
  - OHIC will maintain the following hospital contracting conditions:
    - Health insurers are required to promote quality incentive programs that include: measures from the CMS Hospital Value-based Purchasing Program (for Medicare), measures regarding management of chronic conditions and high-risk patients, and measures derived from the transitions-of-care program as developed by the Medicare Quality Improvement Organization;
    - No advanced payment of quality payments; and
    - Hospital contracts must also define mutual obligations for greater administrative efficiencies, and require active participation in OHIC's Administrative Simplification Work Group.
- Population-Based Contracting Conditions:
  - In their population-based contracts, health insurers must limit increases to the ACO's annual risk-adjusted budget for total medical expenses to the U.S. CPI-Urban less Food and Energy for the Northeast Region plus 1%.

        - OHIC is specifying use of the U.S. CPI-Urban Less Food and Energy as a benchmark for population-based and hospital contracts because it is the most commonly used indicator of consumer cost-of-living change and is a stable benchmark with limited fluctuation.
    - On or before January 1 of each year the Commissioner will solicit comments from stakeholders concerning whether the population-based contract budget limit and transformation targets should be adjusted to:
        - Create an effective incentive for hospitals and providers to participate in care transformation, population-based contracts and alternative payment arrangements; or
        - Account for unanticipated and profound macroeconomic events, or similarly significant changes in systemic utilization or costs that are beyond the ability of the Health Insurer to comply with the budget limit, such that application of the budget limit would be manifestly unfair.
- Data and Evaluation. Health insurers will be required to submit the following quarterly reports:
    - Primary Care Spend Report,
    - Care Transformation Report, and
    - Payment Reform Report.

OHIC shall report to its Health Insurance Advisory Council (HIAC) on revised Affordability Standards implementation as follows:

- Annual monitoring report describing the status of progress in implementing the Affordability Standards and
- On or before October 1, 2018 an evaluation of the Affordability Standards plus options for improving their effectiveness.

Through these modifications to the Affordability Standards, OHIC is working to move the delivery system in a direction that will slow the growth of healthcare costs while improving the efficiency and quality of delivered care.