

Final Public  
Comments for  
Regulation 2  
Revisions  
12/10/14

December 5, 2014

Herbert W. Olson  
Legal Counsel  
Office of the Health Insurance Commissioner  
State of Rhode Island  
1511 Pontiac Avenue, Building 69-1  
Cranston, RI 02920

RE: Proposed Amendments to Regulation 2

Dear Mr. Olson,

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

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

- Investments in Patient Centered Medical Homes which have resulted in: 7% lower patient admissions, 3% fewer readmissions, 17% fewer emergency room visits, and savings of approximately \$11 per (commercial) member per month.
- As of the 1<sup>st</sup> quarter of 2014, approximately 24% of claim dollars were paid under shared savings arrangements with healthcare providers, and we continue to establish additional shared savings arrangements. These models encourage primary care physicians and other providers to manage the total cost of care for patients and reduce the medical expense cost trends for their patients, while also providing incentives to provide high quality care.
- An innovative pilot with Care New England, Butler Hospital, and The Providence Center that is designed to offer patients better continuity and outcomes, and reduce overall behavioral health spending by providing BCBSRI members with access to comprehensive, coordinated, community-based treatment and support services.
- Introduction of plan designs which incent the use of Patient Centered Medical Homes and other high quality, low cost providers.

BCBSRI’s strategic intent is to make healthcare affordable and simple for Rhode Island. Toward that end, our Board of Directors recently approved a four-year strategic plan that is consistent with the objectives set forth in the proposed regulation.

Despite our unequivocal support for and commitment to these goals, we disagree with the path that is outlined in the regulation for the following reasons:

1. The regulation is overly prescriptive. For example, the regulation limits flexibility and management discretion on which investments are most appropriate to make in primary care. It specifies a total amount of total medical expenses that must be spent on primary care, and then specifies how that money must be spent. It does 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 the movement toward integrated systems of care.
2. The regulation continues to hold carriers solely responsible through the rate review process for affordability and payment reform. We accept our role and responsibility in driving these efforts; however, we argue that the rate review process is not the vehicle through which to set healthcare policy. Partnership from and accountability of all healthcare stakeholders is needed to achieve these goals. In addition, the regulation aligns adoption of policy with the rate review process and provides that “any adjustments . . . shall be considered in connection with the annual rate review process . . .” (Section 10(b)(1)(B)) or, failing adoption of a care transformation plan or alternative payment methodology plan by the committees established by the regulation, the Commissioner may require “. . . adoption of a suitable plan as a condition of approval of health Insurers’ rates.” (Section 10(c)(2)(C) and (d)(2)(C)). This is an untenable position for carriers – we would be submitting our rate filings with no insight in to the standards that may be applied in the year for which we are proposing rates.
3. Throughout the regulation there are numerous references to additional “parameters and criteria” (see, e.g., Section 2(c)(3) and (3)(F)), “bulletins” (see, e.g., Section 2(h)), and additional approvals needed from the Commissioner (see, e.g., Section 10(d)(2)(B)). Respectfully, while carriers must be held accountable for driving delivery system transformation and payment reform, we must also have visibility into what we may be accountable for and have flexibility to apply management discretion in order to be responsive to what is or is not working. There is no clear path for this very complicated work. We must be able to respond to emerging data and information and have the flexibility to change course as needed to achieve success. Seeking input or approval, or awaiting regulatory review and quasi-rule making at every turn will slow progress in achieving our goals.

In addition, we believe that the Healthcare Leaders Workgroup convened by Senator Whitehouse and Neil Steinberg has brought a renewed focus and increased level of commitment on the part of healthcare leaders in the State. Through this group, the Commissioner, Peter A., and other healthcare leaders will soon enter into a compact that demonstrates a commitment on the part of key stakeholders including carriers, hospitals, physicians, employer groups, and regulators (among others) to significant healthcare reforms by 2019. This compact calls for on-going public-private partnerships toward the goal of achieving payment reform. Based on the progress that has been made, and the impending compact, we recommend that the Commissioner leverage the existing framework of this 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.

As a result, we recommend that the Commissioner delay adoption of the proposed regulation at this time. In the event the Commissioner does move forward with the proposed regulation, we offer the following detailed comments.

## **Definitions (Section 2)**

*Direct Primary Care Expenses* – It is unclear whether investments in infrastructure development referenced in (c)(3) includes investments in data, analytics and population health tools when developed/adopted by primary care practices. We recommend including these expenses as direct expenses.

*Indirect Primary Care Expenses* – This definition should permit investments in data, analytics, population health and disease registries by carriers in support of primary care practices. Further, to date, carriers have agreed to fund CurrentCare through a per member per month payment pursuant to a private contract with the Rhode Island Quality Institute. The OHIC has no authority to require on-going payments to CurrentCare as this is the equivalent of a tax which is not delegated to OHIC by the General Assembly.

*Integrated System of Care* – This definition requires a single “business entity” in order to have an integrated system of care. Systems of Care should not be limited to legally constructed entities. Instead, the regulation should also recognize and support virtual integration through contractual arrangements as well.

*Patient-Centered Medical Home* – This definition includes primary care practices recognized through CSI-RI or a national accreditation body. It appears that an carrier cannot enter into alternative arrangements with primary care and integrated system of care without the approval of the Commissioner. This is unduly burdensome. Innovative arrangements focused on delivery of high quality, population based, systems of care should be incentivized, not penalized through the requirement of approval.

*Primary Care Practice* – The definition appears to include physicians who have a dual specialty. We disagree and ask that the language “specialty medical 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 responsibilities of a primary care provider” be removed.

## **Affordability Standards (Section 10)**

As discussed above, flexibility should be provided in how investments in primary care, whether direct or indirect, are made by carriers. As drafted, the regulation would require BCBSRI to shift \$2.4 million in direct primary care spend to indirect spend because our current indirect spend is only 0.5%. We believe this is an unintended consequence. Instead, we suggest that a target of 10.7% of total primary care spend be retained but that the requirement to split these investments between direct and indirect expenses as indicated in Section 10(b)(1)(A) be eliminated.

The regulation establishes two new committees for the purposes of adopting (i) a care transformation plan and (ii) an alternative payment methodology plan by May 1<sup>st</sup> of each year (Section 10(c)(2) and (d)(2)(C)). We strongly encourage the commissioner to delete these provisions and instead ask the Healthcare Leaders Workgroup to provide input in to these topics during 2015. Utilizing this workgroup will ensure involvement of key stakeholders and lessen the burden for stakeholders who are called upon

frequently to provide input. In addition, we note that the proposed timing of this work coincides with the preparation and submission of annual rate filings. Requirements must be known sufficiently in advance of a rate filing in order for carriers to anticipate costs and adequately reflect changes in our filings. Ideally, this information would be available to carriers by December 31<sup>st</sup> each year.

We object to the inclusion of yet to be determined funding for an undefined “care transformation plan” based on a “formula established by the Commissioner that is based upon the Health Insurer’s market share and other relevant considerations.” (Section 10(c)(3)) OHIC has no authority to impose such a financial responsibility under applicable law.

Subsection (d) adopts targets for movement toward population-based contracting. In doing so, the regulation establishes both an overall target and targets specifically for the number of covered lives in shared savings and risk sharing contracts (i.e. by 2017, 60% of covered lives in a population based contract with shared savings plus another 20% in a risk sharing population based contract). While laudable, we believe the 2017 target may be aggressive. Therefore, we recommend that the regulation adopt targets for 2015 and 2016, but establish targets for 2017 at a later date. In addition, these are targets which are speculative at this time. We are unclear what the ramifications would be if a carrier were unable, despite reasonable diligence, to achieve these targets

The regulation adopts obligations for carriers to verify the operational and financial capacity and resources of a provider organization seeking to enter in to a risk sharing contract. (Section 10(d)(1)(D)) It imposes on carriers a significant burden, using a false assumption of existing operating procedures in rating manuals, that carriers have the expertise or access to the necessary information to verify such capacity. Carriers will also lack visibility into the total financial obligation of a provider organization across multiple-payers. 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.

Under the proposed regulation, carriers must use and increase their “use of nationally recognized alternative payment methodologies . . . in accordance with a schedule filed by the health insurer and approved by the Commissioner during the annual rate review process.” While we fully support adoption and use of alternative payment methodologies, this is an emerging area of activity and flexibility is needed. National recognition of a payment methodology does not mean that the methodology is the only option, nor does it mean it is the best option. And, as discussed above, the review of alternative payment arrangements must be divorced from the rate review process. OHIC has other authority to examine and conduct oversight of carriers and should consider those options for ensuring compliance rather than enforcement through and conditions upon rate review/approval.

Hospital contract standards proposed in the regulation are directionally consistent with existing Rate Approval Conditions. We believe that the adoption of such conditions in regulation eliminates the need for on-going imposition of such conditions on rate filings after July 1, 2015. We do not support the addition of language in Section 10(d)(3)(D)(v) that prohibits the inclusion of quality incentive payments (those that are earned) in the base rate payments in the succeeding year. We recommend, instead, that earned quality payments be compounded annually, such that the quality payment earned in the prior year remains a risk and is built upon year over year, and that the regulation adopt an overall cap whereby no more than ten percent (10%) of the hospital’s revenue under the contract be earnable for quality unless agreed by the carrier and the hospital. We support the adoption of the new standard on which hospital increases are based – instead of the CMS National Prospective Payment System Hospital Input Price

Index, the regulation proposes that approval of the Commissioner is needed for any increases in excess of either (i) the US All Urban Consumer All Items Less Food and Energy CPI (“CPI-Urban”) for the Northeast Region or (ii) where less than 50% of the increase is expected for quality.

Section 10(d)(4)(B) adopts a cap on increases of CPI-Urban plus one-percent. We recommend that this be revised such that carrier’s may instead contract using the network trend. If the Commissioner is concerned that this is unknown and may be inconsistent across carriers, this section could instead adopt a standard that is the “lower of” network trend or CPI-Urban plus one-percent.

Data collection and evaluation, to the extent practicable, must be based on data available through the All Payer Claims Database (“APCD”). The development of the APCD has required significant investments from the carriers and the State. To require additional data submission from carriers to OHIC is an unnecessary burden and additional administrative expense.

### **Administrative Simplification Standards (Section 11)**

The Administrative Simplification Task Force has provided carriers and providers with a valuable opportunity to build relationships, identify concerns, and resolve issues. We are committed to on-going participation in the Task Force and we support that the Task Force will be guided by a well-defined process and that the discussions will be data-driven. This part of the regulation flows from the work of the Task Force to date, although in parts it follows the March 2014 report to the Assembly (the “Final Report”) and in other parts it proposes processes from earlier drafts (the “Draft Report”). Our comments below are consistent with our comments on both of those reports as well as the proposed inclusion of these elements in the form approval checklist.

#### *Retroactive Terminations:*

The provisions of the proposed regulation relating to retroactive terminations are consistent, generally, with the conversations of the Task Force. As we indicated through the meetings of the Task Force, we have implemented procedures relating to retroactive terminations that, absent regulatory rule making, put BCBSRI at a competitive disadvantage because other carriers have not adopted this process. We appreciate that this regulation creates a level playing field for carriers.

The regulation allows that “carriers may establish reasonable contractual requirements with providers regarding eligibility checks...” however the regulation does not make, and would prohibit carriers from making, eligibility checks a condition for protection provided by this subsection. Carriers should be allowed to place such reasonable conditions on providers. Therefore, we recommend that the regulation add the following language: “Health insurers shall establish written standards and procedures to notify providers of all eligibility determinations electronically or telephonic at the time eligibility determination is requested by the provider. Such a request and determination is a prerequisite to the application of the provisions of this subsection.”

We also recommend that language be added to specifically exempt from the provisions on retroactive termination the following two scenarios:

1. Another carrier/plan is obligated to pay the claim. As we urged in our comments to the Draft Report, the regulation should carve out the situation where the employer, or individual, switched coverage from one carrier/plan (the initial carrier) to another (the new carrier) but the initial

carrier/plan had not been informed and as a result still recorded the person as being enrolled. In that situation, the provider is entitled to payment from the new carrier thus would be held harmless. Language such as the following could be included to effectuate this exemption: “This subsection (c) shall not apply if the health insurer has not collected premium for the period during which the patient received services.”

2. Consistent with the Final Report, this regulatory provision should not apply to COBRA policy holders. Language such as the following could be included to effectuate this exemption: “This subsection shall not apply to COBRA coverage or to any other state or federal programs where a conflict exists.”

*Coordination of Benefits:*

Elements of this subsection are not consistent with the Final Report and instead follow the Draft Report, to which we voiced objections.

In subsection (d)(2), we support the adoption of a common form. However, we disagree with the requirement for submission of the COB process for approval (part ii) as that adds an administrative burden. In addition, so long as carriers accept the common form, they should be allowed greater flexibility to innovate. Therefore, both subsections (d)(2)(ii) and (iii) should be removed.

We continue to object to the inclusion of subsection (d)(2)(v) and request that it be removed. As we stated in our comments to the Draft Report “the requirement to add a flag within the eligibility look-up section of the carrier’s website indicating the last update of COB information should not be an additional requirement. We are concerned that members and providers will interpret the lack of a recent update as a requirement to refresh the information even if it is to simply inform the carrier that the member has no other insurance. Plans would incur expenses to implement this system change and process those forms, but that work would add little or no value.”

Similarly, we continue to object to the requirement to participate in the centralized registry by January 1, 2016. Participation is expensive and only provides sufficient value once the Centers for Medicare and Medicaid (CMS) participates. We raised these concerns in reaction to the Draft Report. The Final Report included a recommendation that we could support: participation should be triggered by CMS’s involvement (page 12-13). Therefore, we recommend that subsection (d)(3) be replaced with the following: “Health insurers shall participate in a centralized registry designated by OHIC, on a date determined in consultation with the health insurers, with full participation occurring no later than one calendar year from the date of use of the designated registry by the Centers for Medicare and Medicaid.”

*Appeals of “Timely Filing” Denials:*

We continue to have concerns consistent with those raised in our comments on the Draft Report. In subsection (e)(2), we recommend the appeal be submitted within 60 days after the denial from that “new” carrier. This is not necessarily longer or shorter than the proposed regulation, but will foster administrative simplicity by making this period consistent with other administrative appeal timelines. In subsections (e)(3) and (4), we urge a change that will facilitate our ability to administer this requirement. The process should be based on a change to the *appeal* rights, not on a change to *claim processing* rules. This will allow us to implement the requirement through changes to our appeals process without necessitating significant changes to our claims processing systems, which could be both costly

Herbert W. Olson  
Office of the Health Insurance Commissioner  
December 5, 2014  
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and contrary to the goals of the administrative simplification task force. To effectuate this comment, a simple change to replace the word “claim” with “appeal” in subsections (e)(3) and (4).

We request that the requirement to submit an appeal checklist to the OHIC for approval be removed. Subsection (e)(3)(A) – (D) describe detailed documentation and process requirements. As a result, additional submissions to the OHIC add an unnecessary layer of administrative work for carriers.

Lastly, as we noted in our comments to the Draft Report, we urge OHIC to consider adopting an additional requirement relating to timely filing. Some timeframe between the date of service and the appeal should be imposed so that carriers can bring finality to their financial accounting. For example, the requirement could limit the carrier’s obligation to 18 months from the date of service. We believe this is a reasonable request given that providers are unlikely to get evidence of this new coverage in the majority of cases after some amount of time.

*Medical Records Management:*

The discussions among the members of the Administrative Simplification task force helped identify some procedural concerns with medical records management, but we opposed this recommendation in the Draft Report and continue to do so now. Carriers and providers already operate under significant state and federal laws relating to maintaining patient confidentiality. Both as a result of the discussions at the Task Force and independently, plans are working to reduce the administrative burden of the medical records submission process. For this reason, we recommend that this provision be removed.

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

Sincerely,



Monica A. Neronha  
Vice President, Legal Services

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





CharterCARE  
HEALTH PARTNERS

December 5, 2014

Herbert W. Olson, Legal Counsel  
Office of the Health Insurance Commissioner  
1511 Pontiac Avenue, Building 69-1  
Cranston, RI 02920

Dear Attorney Olson:

Please find attached comments submitted on behalf of CharterCare Health Partners to the proposed amendments to Regulation 2 – Powers and Duties of the Office of the Health Insurance Commissioner.

As you may know, CharterCare Health Partners and Prospect Medical Holdings recently came together to form an innovative joint venture. As such, we look forward to building upon the long traditions of Roger Williams Medical Center and Our Lady of Fatima hospitals, along with their numerous community clinics, extended care facilities, and other outreach services, of providing high-quality care in the most efficient manner possible.

Prospect has worked in various risk-sharing and full risk provider payment models in California and other jurisdictions, and welcomes the discussion and introduction of these innovative models for the benefit of the citizens of Rhode Island. In addition to providing the written comments attached, we would appreciate the opportunity to discuss with you and your staff our experiences in other states and our interest in applying these types of payment models in Rhode Island.

Thank you again for the opportunity to provide comments to the proposed amendments and we look forward to working with you and your office in the future.

Sincerely,

Lester P. Schindel  
Chief Executive Officer

**State of Rhode Island and Providence Plantations  
OFFICE OF THE HEALTH INSURANCE COMMISSIONER  
1511 Pontiac Avenue, Building 69-1  
Cranston, RI 02920**

**OFFICE OF THE HEALTH INSURANCE COMMISSIONER REGULATION 2**

**POWERS AND DUTIES OF THE OFFICE OF THE HEALTH INSURANCE  
COMMISSIONER**

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***Section 1***     **Authority**

This regulation is promulgated pursuant to R.I. Gen. Laws §§ 42-14.5-1 *et seq.*, 42-14-5, 42-14-17 and 42-35-1 *et seq.*

***Section 2***     **Purpose and Scope**

When creating the Office of the Health Insurance Commissioner (OHIC or Office), the General Assembly created a list of statutory purposes for the OHIC at R.I. Gen. Laws § 42-14.5-2 (the OHIC Purposes Statute). In order to meet the requirements established by the OHIC Purposes Statute, the OHIC has developed this regulation, which is designed to:

- ensure effective regulatory oversight by the OHIC;
- provide guidance to the state’s health insurers, health care providers, consumers of health insurance, consumers of health care services and the general public as to how the OHIC will interpret and implement its statutory obligations; and
- implement the intent of the General Assembly as expressed in the OHIC Purposes Statute.

**Section 3 Definitions**

As used in this regulation:

(a) "Affiliate" has the same meaning as set out in the first sentence of R.I. Gen. Laws § 27-35-1(a). An "affiliate" of, or an entity or person "affiliated" with, a specific entity or person, is an entity or person who directly or indirectly through one or more intermediaries controls, or is controlled by, or is under common control with, the entity or person specified.

(b) "Commissioner" means the Health Insurance Commissioner.

(c) "Direct Primary Care Expenses" means payments by the Health Insurer Issuer directly to a primary care practice for:

(1) providing health care services, including fee-for service payments, capitation payments, and payments under other alternative, non-fee-for-service methodologies designed to provide incentives for the efficient use of health services;

(2) achieving quality or cost performance goals, including pay-for-performance payments and shared savings distributions;

(3) infrastructure development payments within the primary care practice, in accordance with parameters and criteria issued by order of the Commissioner:

(A) that are designed to transform the practice into a Patient Centered Medical Home, and to prepare a practice to function within an Integrated System of Care;

(B) that promote the appropriate integration of primary care and behavioral health care;

(C) for shared services among small and independent primary care practices to enable the practices to function as Patient Centered Medical Homes;

(D) that promote community-based services to enable practices to function as Patient Centered Medical Homes;

(E) designed to increase the number of primary care physicians practicing in RI, and approved by the Commissioner, such as a medical school loan forgiveness program; and

(F) any other direct primary care expense that meets the parameters and criteria established in a bulletin issued by the Commissioner.

(ed) "Examination" has the same meaning as set out in R.I. Gen. Laws § 27-13.1-1 *et seq.*

(e) "Global Capitation Contract" means an agreement with an Integrated System of Care that (i) holds the Integrated System of Care contractually responsible for providing or arranging all or a substantial part of the professional and institutional care delivered to a health insurer's defined group of members in return for a monthly global capitation payment based upon a negotiated percentage of the health insurer's premium or a negotiated fixed per member per month payment, and (ii) incorporates incentives and/or penalties for performance relative to quality targets.

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(dfe) “Health insurance” shall mean “health insurance coverage,” as defined in R.I. Gen. Laws §§ 27-18.5-2 and 27-18.6-2, “health benefit plan,” as defined in R.I. Gen. Laws § 27-50-3 and a “medical supplement policy,” as defined in R.I. Gen. Laws § 27-18.2-1 or coverage similar to a Medicare supplement policy that is issued to an employer to cover retirees.

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practice, or other medical provider considered by the insured subscriber or dependent to be,

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his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Practice, Internal Medicine and Pediatrics; and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants; except that specialty medical 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.

(n) "Risk Sharing Contract" means an agreement that (i) holds the provider financially responsible for a negotiated portion of costs that exceed a predetermined population-based budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget, and (ii) incorporates incentives and/or penalties for performance relative to quality targets.

~~(m)~~ (o) "Shared Savings Contract" means an agreement that (i) allows the provider to share in a portion of any savings generated below a predetermined population-based budget, and (ii) incorporates incentives or penalties for performance relative to quality targets.

#### ***Section 4 Discharging Duties and Powers***

The Commissioner shall discharge the powers and duties of the Office to:

- (a) Guard the solvency of health insurers;
- (b) Protect the interests of the consumers of health insurance;
- (c) Encourage fair treatment of health care providers by health insurers;
- (d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- (e) View the health care system as a comprehensive entity and encourage and direct health insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

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**Section 5**      **Guarding the Solvency and Financial Condition of Health Insurers**

- (a) The solvency of health insurers must be guarded to protect the interests of insureds, health care providers, and the public generally.
- (b) Whenever the Commissioner determines that
  - (i) the solvency or financial condition of any health insurer is in jeopardy or is likely to be in jeopardy;
  - (ii) any action or inaction by a health insurer could adversely affect the solvency or financial condition of that health insurer;
  - (iii) the approval or denial of any regulatory request, application or filing by a health insurer could adversely affect the solvency or financial condition of that health insurer; or
  - (iv) any other circumstances exist such that the solvency or financial condition of a health insurer may be at risk

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to the solvency or financial health of a health insurer, act to guard the solvency and financial condition of a health insurer when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

- (c) When making a determination as described in subsection (b) of this section or when acting to guard the solvency of a health insurer, the Commissioner may consider and/or act upon the following solvency and financial factors, either singly or in combination of two or more:
  - (i) any appropriate financial and solvency standards for the health insurer, including those set out in title 27 of the General Laws and implementing regulations;
  - (ii) the investments, reserves, surplus and other assets and liabilities of a health insurer;
  - (iii) a health insurer's use of reinsurance, and the insurer's standards for ceding, reporting on, and allowing credit for such reinsurance;
  - (iv) a health insurer's transactions with affiliates, agents, vendors, and other third parties to the extent that such transactions adversely affect the financial condition of the health insurer;
  - (v) any audits of a health insurer by independent accountants, consultants or other experts;



- (vi) the annual financial statement and any other report prepared by or on behalf of a health insurer related to its financial position or financial activities;
- (vii) a health insurer's transactions within an insurance holding company system;
- (viii) whether the management of a health insurer, including its officers, directors, or any other person who directly or indirectly controls the operation of the health insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in the position;
- (ix) the findings reported in any financial condition or market conduct examination report and financial analysis procedures;
- (x) the ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income, which could lead to an impairment of capital and surplus;
- (xi) concerns that a health insurer's asset portfolio, when viewed in light of current economic conditions, is not of sufficient value, liquidity, or diversity to ensure the health insurer's ability to meet its outstanding obligations as such obligations mature;
- (xii) the ability of an assuming reinsurer to perform and whether the health insurer's reinsurance program provides sufficient protection for the health insurer's remaining surplus after taking into account the health insurer's cash flow and the classes of business written and the financial condition of the assuming reinsurer;
- (xiii) the health insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent of the health insurer's remaining surplus as regards policyholders in excess of the minimum required;
- (xiv) whether any affiliate, subsidiary, or reinsurer of a health insurer is insolvent, threatened with insolvency, or delinquent in the payment of its monetary or other obligations;
- (xv) any contingent liabilities, pledges, or guaranties of a health insurer that either individually or collectively involve a total amount which in the opinion of the Commissioner may affect the solvency of the health insurer;
- (xvi) whether any person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a health insurer, is delinquent in the transmitting to, or payment of, net premiums to the insurer;
- (xvii) the age and collectibility of a health insurer's receivables;

- (xviii) whether the management of a health insurer has
  - (A) failed to respond to inquiries by the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency relative to the financial condition of the health insurer;
  - (B) furnished false and misleading information concerning an inquiry by the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency regarding the financial condition of the health insurer; or
  - (C) failed to make appropriate disclosures of financial information to the Commissioner, the Department of Business Regulation, the Department of Health, the Department of the Attorney General, any other state or federal agency, or the public.
- (xix) whether the management of a health insurer either has filed any false or misleading sworn financial statement, or has released a false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the health insurer;
- (xx) whether a health insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner; and
- (xxi) whether a health insurer has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.
- (d) The factors enumerated in subsection (c) of this section shall not be construed as limiting the Commissioner from making a finding that other factors not specifically enumerated in subsection (c) are necessary or desirable factors for the evaluation and maintenance of the sound financial condition and solvency of a health insurer.

**Section 6**     *Protecting the Interests of Consumers*

- (a) The interests of the consumers of health insurance, including individuals, groups and employers, must be protected.
- (b) The provisions of this regulation do not require the Commissioner to act as an advocate on behalf of a particular health insurance consumer. Instead, while the Commissioner will endeavor to address individual consumer complaints as they arise, the OHIC Purposes Statute requires the OHIC to protect the interests of health insurance consumers, including individuals, groups and employers, on a system-wide basis.

- (c) Whenever the Commissioner determines that
- (i) the interests of the state's health insurance consumers are, or are likely to be, adversely affected by any policy, practice, action or inaction of a health insurer;
  - (ii) the approval or denial by the Commissioner of any regulatory request, application or filing made by a health insurer could adversely affect the interests of the state's health insurance consumers; or
  - (iii) any other circumstances exist such that the interests of the state's health insurance consumers may be adversely affected

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to the protection of the interests of the consumers of health insurance, act to protect the interests of consumers of health insurance when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

- (d) When making a determination as described in subsection (c) of this section or when acting to protect the interests of the state's health insurance consumers, the Commissioner may consider and/or act upon the following consumer interest issues, either singly or in combination of two or more:
- (i) the privacy and security of consumer health information;
  - (ii) the efforts by a health insurer to ensure that consumers are able to
    - (A) to read and understand the terms and scope of the health insurance coverage documents issued or provided by the health insurer and
    - (B) make fully informed choices about the health insurance coverage provided by the health insurer;
  - (iii) the effectiveness of a health insurer's consumer appeal and complaint procedures;<sup>1</sup>
  - (iv) the efforts by a health insurer to ensure that consumers have ready access to claims information;
  - (v) the efforts by a health insurer to increase the effectiveness of its communications with its insureds, including, but not limited to, communications related to the insureds' financial responsibilities;
  - (vi) that the benefits in health insurance coverage documents issued or provided by a health insurer are consistent with state laws;

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<sup>1</sup> For matters other than medical necessity and utilization review, which are within the jurisdiction of the Department of Health.

- (vii) that the benefits delivered by a health insurer are consistent with those guaranteed by the health insurance coverage documents issued or provided by the health insurer; and
  - (viii) the steps taken by a health insurer to enhance the affordability of its products, as described in section 9 of this regulation.
- (e) The factors enumerated in subsection (d) of this section shall not be construed as limiting the Commissioner from making a finding that other consumer protection issues not specifically enumerated in subsection (d) are necessary or desirable factors upon which the Commissioner may act to protect the interests of consumers of health insurance.

***Section 7      Encouraging Fair Treatment of Health Care Providers***

- (a) The Commissioner will act to encourage the fair treatment of health care providers by health insurers.
- (b) The provisions of this regulation do not require the Commissioner to act as an advocate for a particular health care provider or for a particular group of health care providers. Instead, while the Commissioner will endeavor to address individual health care provider complaints as they arise, the OHIC Purposes Statute requires the OHIC to act to enhance system-wide treatment of providers.
- (c) Whenever the Commissioner determines that
  - (i) health care providers are being treated unfairly by a health insurer;
  - (ii) the policies or procedures of a health insurer place an undue, inconsistent or disproportionate burden upon a class or providers;
  - (iii) the approval or denial by the Commissioner of any regulatory request, application or filing made by a health insurer will result in unfair treatment of health care providers by a health insurer; or
  - (iv) any other circumstances exist such that Commissioner is concerned that health care providers will be treated unfairly by a health insurer

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to the fair treatment of health care providers, take the treatment of health care providers by a health insurer into consideration when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

- (d) When making a determination as described in subsection (c) of this section or when acting to encourage the fair treatment of providers, the Commissioner may consider and/or act upon the following issues, either singly or in combination of two or more:

- (i) the policies, procedures and practices employed by health insurers with respect to provider reimbursement, claims processing, dispute resolution, and contracting processes;
  - (ii) a health insurer's provider rate schedules; and
  - (iii) the efforts undertaken by the health insurers to enhance communications with providers.
- (e) The factors enumerated in subsection (d) of this regulation shall not be construed as limiting the Commissioner from making a finding that other factors related to the treatment of health care providers by a health insurer not specifically enumerated are necessary or desirable factors for the evaluation of whether health care providers are being treated fairly by a health insurer.<sup>2</sup>

**Section 8 *Improving the Efficiency and Quality of Health Care Delivery and Increasing Access to Health Care Services***

- (a) Consumers, providers, health insurers and the public generally have an interest in
- (i) improving the quality and efficiency of health care service delivery and outcomes in Rhode Island;
  - (ii) viewing the health care system as a comprehensive entity; and
  - (iii) encouraging and directing insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.
- (b) The government, consumers, employers, providers and health insurers all have a role to play in increasing access to health care services and improving the quality and efficiency of health care service delivery and outcomes in Rhode Island. Nevertheless, the state's health insurers, because of their prominent role in the financing of health care services, bear a greater burden with respect to improving the quality and efficiency of health care service delivery and outcomes in Rhode Island, treating the health care system as a comprehensive entity, and advancing the welfare of the public through overall efficiency, improved health care quality, and appropriate access. Furthermore, a balance must be struck between competition among the health plans, which can result in benefits such as innovation, and collaboration, which can promote consumer benefits such as standardization and simplification.
- (c) Whenever the Commissioner determines that
- (i) the decision to approve or deny any regulatory request, application or filing made by a health insurer
    - (A) can be made in a manner that will

<sup>2</sup>The factors that may be considered by the Commissioner will not typically include those matters over which other agencies, such as the Department of Health, have jurisdiction.

- (1) improve the quality and efficiency of health care service delivery and outcomes in Rhode Island;
  - (2) view the health care system as a comprehensive entity; or
  - (3) encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access; or
- (B) should include conditions when feasible that will
- (1) promote increased quality and efficiency of health care service delivery and outcomes in Rhode Island;
  - (2) incent health insurers to view the health care system as a comprehensive entity; or
  - (3) encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access; or
- (ii) any other circumstances exist such that regulatory action by the Commissioner with respect to a health insurer will likely improve the efficiency and quality of health care delivery and increase access to health care services

the Commissioner shall, in addition to exercising any duty or power authorized or required by titles 27 or 42 of the General Laws related specifically to improving the efficiency and quality of health care delivery and increasing access to health care services, act to further the interests set out in subsection (a) of this section when exercising any other power or duty of the Office, including, but not limited to, approving or denying any request or application; approving, denying or modifying any requested rate; approving or rejecting any forms, trend factors, or other filings; issuing any order, decision or ruling; initiating any proceeding, hearing, examination, or inquiry; or taking any other action authorized or required by statute or regulation.

- (d) When making a determination as described in subsection (c) of this section or when acting to further the interests set out in subsection (a) of this section, the Commissioner may consider and/or act upon the following, either singly or in combination of two or more:
- (i) Efforts by health insurers to develop benefit design and payment policies that:
    - (A) enhance the affordability of their products, as described in section 9 [and 10](#) of this regulation;
    - (B) encourage more efficient use of the state's existing health care resources;
    - (C) promote appropriate and cost effective acquisition of new health care technology and expansion of the existing health care infrastructure;

- (D) advance the development and use of high quality health care services (e.g., centers of excellence); and
- (E) prioritize the use of limited resources.
- (ii) Efforts by health insurers to promote the dissemination of information, increase consumer access to health care information, and encourage public policy dialog about increasing health care costs and solutions by:
  - (A) providing consumers timely and user-friendly access to health care information related to the quality and cost of providers and health care services so that consumers can make well informed-decisions;
  - (B) encouraging public understanding, participation and dialog with respect to the rising costs of health care services, technologies, and pharmaceuticals; the role played by health insurance as both a financing mechanism for health care and as a hedge against financial risk for the consumers of health care; and potential solutions to the problems inherent in the health insurance market (e.g., market concentration, increasing costs, the growing population of uninsureds, market-driven changes to insurance products (such as the growth of high deductible plans) and segmentation of the insurance market due to state and federal laws); and
  - (C) providing consumers timely and user friendly access to administrative information, including information related to benefits; eligibility; claim processing and payment; financial responsibility, including deductible, coinsurance and copayment information; and complaint and appeal procedures;
- (iii) Efforts by health insurers to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities, including
  - (A) participation in administrative standardization activities to increase efficiency and simplify practices; and
  - (B) efforts to develop standardized measurement and provider payment processes to promote the goals set out in this regulation;
- (iv) Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote quality, access and efficiency;
- (v) Participating in the development and implementation of public policy issues related to health, including
  - (A) collaborating with state and local health planning officials;
  - (B) participating in the legislative and regulatory processes; and
  - (C) engaging the public in policy debates and discussions.

- (e) The factors enumerated in subsection (d) of this section shall not be construed as limiting the Commissioner from making a finding that other factors may be considered when acting to further the interests set out in subsection (a) of this section.

***Section 9     Affordable Health Insurance - General***

- (a) Consumers of health insurance have an interest in stable, predictable, affordable rates for high quality, cost efficient health insurance products. Achieving an economic environment in which health insurance is affordable will depend in part on improving the performance of the Rhode Island health care system as a whole, including but not limited to the following areas:
  - (i) Improved primary care supply, measured by the total number of primary care providers, and by the percentage of physicians identified as primary care providers.
  - (ii) Reduced incidence of hospitalizations for ambulatory care-sensitive conditions, and of re-hospitalizations.
  - (iii) Reduced incidence of emergency room visits for ambulatory care-sensitive conditions.
  - (iv) Reduced rates of premium increase for fully insured, commercial health insurance.
- (b) In discharging the duties of the Office, including but not limited to the Commissioner's decisions to approve, disapprove, modify or take any other action authorized by law with respect to a health insurer's filing of health insurance rates or rate formulas under the provisions of Title 27 or title 42, the Commissioner may consider whether the health insurer's products are affordable, and whether the carrier has implemented effective strategies to enhance the affordability of its products.
- (c) In determining whether a carrier's health insurance products are affordable, the Commissioner may consider the following factors:
  - (i) Trends, including:
    - (A) Historical rates of trend for existing products;
    - (B) National medical and health insurance trends (including Medicare trends);
    - (C) Regional medical and health insurance trends; and
    - (D) Inflation indices, such as the Consumer Price Index and the medical care component of the Consumer Price Index.
  - (ii) Price comparison to other market rates for similar products (including consideration of rate differentials, if any, between not-for-profit and for-profit insurers in other markets);
  - (iii) The ability of lower-income individuals to pay for health insurance;



- (iv) Efforts of the health insurer to maintain close control over its administrative costs;
  - (v) Implementation of effective strategies by the health insurer to enhance the affordability of its products; and
  - (vi) Any other relevant affordability factor, measurement or analysis determined by the Commissioner to be necessary or desirable to carry out the purposes of this Regulation.
- (d) In determining whether a health insurance carrier has implemented effective strategies to enhance the affordability of its products, the Commissioner may consider the following factors:
- (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 and effective incentives for consumers, employers, providers and the insurer itself. Such incentives shall be designed to promote 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;<sup>3</sup> and
    - (D) Promoting use of evidence based, quality care.
  - (iii) Whether the insurer employs provider payment delivery system reform and payment reform strategies to enhance cost effective utilization of appropriate services. Such delivery system reform and payment reform strategies for insurers with greater than 10,000 covered lives shall include, but not be limited to the requirements of Section 10. Consideration may also be given to: (I) whether the insurer supports product offerings with simple and cost effective administrative processes for providers and consumers; (II) whether the insurer addresses consumer need for cost information through increasing the availability of provider cost information and promoting public conversation on trade-offs and cost effects of medical choices; and (III) whether the insurer allows for an appropriate contribution to surplus payment strategies set forth or authorized in subdivisions (A) through (D) of this subdivision (iii). The Commissioner, on petition by a health insurer for good cause shown, or in his or her own discretion, may modify or waive one or more of the provisions of this subdivision (iii):

<sup>3</sup> This goal is meant to apply in the aggregate. Use of some higher cost providers and settings do result in better outcomes and should not be discouraged.

- (A) ~~Financial support for primary care services. The health insurer shall provide adequate financial support for primary care services, in accordance with the provisions of this subdivision (A).~~
- (1) ~~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 6% to 7% of medical expense) than reflected in actual spending for the twelve months starting January 1, 2008. The proportion shall continue to increase by one percentage point per year for five years (until December 31, 2014). The commissioner may reduce carriers' targeted primary care spend rate in a given year following the public planning process established in subdivision (3) of this subdivision (iii)(A). A health insurer's targeted primary care spend rate in a given year (the proportion of the insurer's medical expense allocated to primary care) shall be calculated in accordance with this section.~~
- (2) ~~Health insurers shall submit a Primary Care Spend Report to the Commissioner on or before April 1 of each year, in a manner prescribed by the Commissioner. The Report shall use a template produced by the OHIC and posted on the OHIC website.~~
- (1) ~~The Report shall document historical insurer total medical and primary care spend in detail, and shall include spending history through the prior calendar year. The Report shall document for the next preceding calendar year, for all fully insured commercial business, all medical payments made to primary care providers in Rhode Island, regardless of where the member resides. Payments shall be reported as both total dollars spent during the time period and as a percentage of total medical payments during the time period. Any prescription drug "carve outs" shall be reported on by carriers on their primary care spend reports. Medical payments shall be separately reported by payment for services (e.g., CPT codes, capitation, etc.); and by incentive or bonus payments, including both performance and infrastructure payments.~~
- (II) ~~Health insurers shall also submit to the Commissioner an estimated Primary Care Spend Report on September 1 of each calendar year, documenting anticipated primary care spending for the current calendar year.~~
- (3) ~~By July 1 of a each year, each health insurer shall enter into a public planning process with the Commissioner to determine the most appropriate usage of the additional monies to be spent in the next calendar year with priority given to uses that align the interests and actions of primary care providers and patients in improving the affordability of health insurance. As a result of this process, no later than October 1 of each year through 2013, each health insurer shall submit to the Commissioner, in a manner approved by the Commissioner, an itemized budget with its targeted primary care spending for the coming year and the anticipated uses of those funds. This proposed budget, along with any~~

quarterly adjustments, shall be reported to the Commissioner in the following manner:

- (I) ~~An Annual Investment Plan, documenting each health insurer's proposed investments in primary care for the following calendar year, shall be submitted as of October 1<sup>st</sup> of each year in accordance with a mutually-agreed to template.~~
- (II) ~~A Quarterly Investment Plan Forecast, updating each health insurer's investment plan, for up to date information on actual spending vs. plan, implementation deadline changes, new and cancelled categories of investment, etc. shall be submitted in January, April, July, and October, in accordance with a template produced approved by the Commissioner and posted on the OHIC website.~~
- (III) ~~Health insurers shall work with the Commissioner and other stakeholders to refine the definition of primary care and to monitor past performance and determine future targets for primary care spending.~~
- (4) ~~Consistent with the development of the incentives established in subdivision (d)(ii), for plan years commencing after December 31, 2011 each health insurer shall collect information on the subscriber's and dependent's primary care provider at the time of enrollment and annually thereafter from all commercially insured subscribers and any dependents reside in Rhode Island, consistent with the following standards and procedures. Designation of a primary care provider shall not be a condition of enrollment, and failure to designate a primary care provider shall not constitute grounds for cancellation of coverage. The insurer's obligation to collect such information is limited to primary care providers with a participating provider contract with the carrier, and to primary care providers who are available to accept the subscriber or his or her dependent:
  - (I) ~~Annual updating of this information may occur either at the time of contract renewal or during an annual updating period for all subscribers, as selected by the insurer. Information at enrollment may be collected in the format and means deemed most efficient and effective by the insurer.~~
  - (II) ~~Once the information is collected, the insurer shall record the name of the primary care provider in the electronic enrollment and eligibility record of each subscriber and dependent. The insurer may use this information as appropriate for purposes including but not limited to benefit plan design and adjudication, provider reporting, provider and patient communications and provider payment.~~
  - (III) ~~The insurer shall report to the OHIC by April 1 of each year in correspondence from senior management its efforts in the previous 12 months at collecting the information required by this subsection (e), an assessment, using response rates, utilization data, or other reasonable assessment mechanism of the information's comprehensiveness and~~~~

accuracy, and the insurer's plans for improving collection methods, if appropriate, in the coming year.

(5) ~~As used in this subdivision (A):~~

~~(I) "Payment" means paid claims.~~

~~(II) "Medical payments" exclude payments for prescription, lab, and imaging services.~~

~~(III) "Primary care provider" means the physician, medical practice, or other medical provider considered by the insured subscriber or dependent to be his or her usual source of care. Designation of a primary care provider shall be limited to providers within the following practice type: Family Practice, Internal Medicine and Pediatrics; and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians' Assistants; except that specialty medical 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.~~

~~(IV) "Total medical payments" includes all payments made to Rhode Island facilities and providers, regardless of where the member resides. The term includes prescription drugs, behavioral health, lab, and imaging services. The term includes any secondary payer payments. With respect to prescription drug payments, the term includes payments in Rhode Island only. In connection with Blue Cross Blue Shield of Rhode Island prescription drug payments, the term includes only those payments made to pharmacies in Rhode Island, plus mail order payments. The health insurer shall report prescription drug carve out payments by adjusting the percentage of members with pharmacy benefits, and that percentage shall be included in ongoing reporting. Any prescription drug carve outs payments shall also be reported on by carriers on their primary care spend reports.~~

~~(B) All Payer Patient Centered Medical Home Initiative. Each health insurer shall participate in and provide adequate financial support of the patient centered medical home collaborative convened by the health insurance commissioner and the secretary of of the Executive Office of Health and Human Services, in accordance with the provisions of R.I. Gen. Laws chapter 42-14.6.~~

~~(C) Electronic Health Record Incentive Payment. Each health insurer shall provide effective financial support for provider adoption of electronic health records, in accordance with the provisions of this subdivision (C). Such support shall include incentive payments to providers, if the following eligibility criteria are met:~~

~~(1) Eligible providers must demonstrate "meaningful use" of electronic health records, as defined by the Electronic Health Records Program of the~~

~~Center for Medicare and Medicaid Services (“EHR Program”), and in accordance with the eligibility criteria of the EHR Program.~~

- ~~(2) — Eligible providers must, in addition to the requirements of subdivision (C)(1):~~
  - ~~(I) — demonstrate routine and consistent enrollment of patients in the “currentcare” program, as established and administered by the Rhode Island Quality Institute, and, if applicable;~~
  - ~~(II) — enroll in the Rhode Island Regional Extension Center, and participate in the Direct Project, if the provider is eligible for such programs under criteria established and administered by the Rhode Island Quality Institute.~~
  - ~~(3) — The amount per eligible provider and the form of such incentive payments shall be determined by the health insurer. The payments shall be reasonably consistent with the amount and the form of payments to an eligible provider by the EHR Program, and reasonably consistent with the relative size of total payments to that eligible provider by the health insurer compared to payments to other eligible providers. The health insurer shall submit a plan to OHIC by November 1 of each year documenting its Electronic Health Record Incentive Program for the following calendar year.~~
  - ~~(4) — Health insurers’ incentive payment obligations under this subdivision (C) are contingent upon the timely submission of quarterly provider enrollment data by the Rhode Island Quality Institute to OHIC and to each health insurer, consistent with a memorandum of understanding entered into between OHIC and the Rhode Island Quality Institute.~~
  - ~~(D) — Cost Effective Contracting with Hospitals. Each health insurer that contracts with hospitals in Rhode Island for services to commercially enrolled members shall include in each hospital contract the terms set forth in, or authorized by subdivisions (1) through (7) of this subdivision (D). Such contracts shall:~~
    - ~~(1) — Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service, i.e. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.~~
    - ~~(2) — Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective~~

~~Payment System Hospital Input Price Index (“Index”), for all contractual and optional years covered by the contract. The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year. Upon written request of a health insurer, supported by the hospital's written agreement with the health insurer's request, the Commissioner may approve exceptions to the Index limit for those hospital contracts which the health insurer demonstrates, to the Commissioner's satisfaction, align significant financial responsibility for the total costs of care for a defined population and set of services in manners generally consistent with the alternative Medicare payment mechanisms proposed under the Affordable Care Act. Health insurers are encouraged to file such requests.~~

- (3) ~~Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract over the previous contract year by attaining mutually agreed to performance levels for all or a subset of measures in the CMS Hospital Value Based Purchasing Program for Medicare. A health insurer's quality incentive program may also include one or more of the following: (i) other nationally accepted clinical quality, service quality, or efficiency based measures; (ii) mutually agreed upon metrics of clinical quality that may have no clear precedent nationally, and (iii) mutually agreed upon clinical quality improvement activities that support new models of care coordination. The measures, performance levels, payment levels, and payment mechanisms must be articulated in the contract. A health insurer may make interim payments in the event that interim measures of performance have been met; provided that the interim payments must be commensurate with the achievement of the interim measures; and provided further that a final settlement may only occur after the measurement period; and provided further that if the annual measures of performance have not been achieved, the hospital shall be required to remit interim payments back to the health insurer.~~
- (4) ~~Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify explicit commitments on the part of each party. On or before January 1 of each year, each health insurer shall file with OHIC a report approved by the Commissioner identifying and describing for each hospital or hospital system the specific programs or initiatives designed to achieve greater administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the carrier and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the carrier and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital~~

system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, of a calendar year, the health insurer shall have 90 days from the date the contract is signed to submit a report in accordance with this subdivision (4) with respect to such contract.

- (5) — Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO) in a format and on a schedule determined by the Medicare QIO its performance for the following nine best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care: (1) notify primary care physician ("PCP") about hospital utilization, (2) provide receiving clinicians with hospital clinician's contact information upon discharge, (3) provide patient with effective education prior to discharge, (4) provide patient with written discharge instructions prior to discharge, (5) provide patient with follow up phone number prior to discharge, (6) perform medication reconciliation prior to discharge, (7) schedule patient outpatient follow up appointment prior to discharge, (8) provide PCP with summary clinical information at discharge, and (9) invite PCP to participate in end of life discussions during hospital visit.
- (6) — 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; provided that the issuer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality. Any contractual language forbidding the disclosure of contractual or payment information shall have: (i) a specific exemption for payment information shared to or by providers in shared risk arrangements similar to those described in subdivision (1) above, who seek such information for the purposes of improved care coordination, or support for innovative provider payment arrangements, and (ii) an affirmative obligation of the health insurer to provide such payment information to those providers when requested.
- (7) — Include such other terms as the Commissioner determines, after notice and an opportunity for public comment, will enhance the cost effective utilization of appropriate services:
  - (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.

- (vi) ~~Whether the insurer allows for an appropriate contribution to surplus.~~
- (e) The following constraints on affordability efforts will be considered:
  - (i) State and federal requirements (e.g., state mandates, federal laws).
  - (ii) Costs of medical services over which plans have limited control.
  - (iii) Health plan solvency requirements.
  - (iv) The prevailing financing system in United States (i.e., the third-party payor system) and the resulting decrease in consumer price sensitivity.
  - (f) ~~Review of Payment Strategies. By June 2014 and no less than biennially afterwards, the Health Insurance Advisory Council of the Office of the Health Insurance Commissioner will review the payment strategies established in subsection (d) of this Section 9 and recommend to the Commissioner adjustments deemed necessary to improve efficacy of the payment strategies based on the following considerations:~~
    - (i) ~~Performance of Rhode Island on the system measures articulated at the beginning of this section.~~
    - (ii) ~~Feedback of health plans, providers, employers and other stakeholders.~~
    - (iii) ~~Expert opinion.~~
    - (iv) ~~Best practices in other communities.~~

**Section 10. Affordable Health Insurance – Affordability Standards**

(a) Health Insurers with at least 10,000 covered lives shall comply with the delivery system and payment reform strategy requirements set forth in this Section.

(b) Primary care spend obligation. The purpose of this Subsection (b) is to ensure sufficient financial support for primary care providers in Rhode Island, in order that the goals of these Affordability Standards can be achieved.

(1)(A) Each Health Insurer’s annual, actual primary care expenses shall be at least 10.7 percent of its annual medical expenses for all insured lines of business. Of the Health Insurer’s annual financial obligation, at least 9.7 percent of annual medical expenses shall be for Direct Primary Care expenses. Each Health Insurer shall spend at least 1 percent of its annual medical expenses on Indirect Primary Care expenses, provided that in no event may the amount spent by each Health Insurer for the administrative expenses of the medical home initiative endorsed by RIGL Chapter 42-14.6, and for the health information exchange established by RIGL Chapter 5-37.7 be reduced from the amount spent for such purposes in calendar year 2014.

(B) The Commissioner may reassess the primary care spending obligations set forth in Subdivision (1)(A), in order to determine whether any adjustments would better achieve the purposes of supporting primary care as an affordability strategy. The reassessment may include a determination of whether the Health Insurer's obligation to provide financial support for the health information exchange established by RIGL Chapter 5-37.7 should continue. Any adjustments proposed by the Commissioner shall be considered in connection with the annual rate review process conducted by the Office.



The reassessment may include a national survey of health care systems with a reputation for high performance and a commitment to primary care for the purposes of quantifying primary care spending in those systems.

(2) Direct Primary Care Expenses shall be accounted for as medical expenses on the Health Insurer's annual financial statement, and on its RI annual health supplemental statement. Indirect Primary Care Expenses shall be accounted for as administrative costs on the Health Insurer's annual financial statement, and on its RI annual health supplemental statement. Indirect Primary Care Expenses may be deducted from each statement's administrative cost category as cost containment expenses, in accordance with federal Medical Loss Ratio calculation rules.

(3) In meeting its annual primary care spend obligations, a Health Insurer's insured covered lives shall not bear a financial burden greater than their fair share of expenses that benefit both insured covered lives, and non-insured covered lives whose health plans are administered by the Health Insurer.

(c) Primary care practice transformation. The purpose of this Subsection (c) is to transform how primary care is delivered in Rhode Island, in order that the goals of these Affordability Standards can be achieved. While primary care practice transformation should not be considered an ultimate goal in itself, the Commissioner finds that it produces higher quality and potentially lower cost care and is a necessary foundation for the effective transition of practices into Integrated Systems of Care.

(1) Each Health Insurer shall take such actions as are necessary so that, no later than December 31, 2019, 80 percent of the Primary Care Practices contracting with the Health Insurer are functioning as a Patient-Centered Medical Home or an Integrated System of Care, as defined in Subsection (g)(4). Such actions shall include but not be limited to contractual incentives for practices participating in a Patient-Centered Medical Home or Integrated Systems of Care, and contractual disincentives for practices that are not participating in such care transformation practices.

(2)(A) The Commissioner shall convene a Care Transformation Advisory Committee by February 1, 2015, and by January 1 of each year thereafter, composed of stakeholders designated by the Commissioner. The Committee shall be charged with developing an annual care transformation plan designed to achieve the 80 percent requirement established in Subsection (c)(1).

(B) The care transformation plan shall recommend, for approval by the Commissioner: (i) annual care transformation targets prior to 2019, (ii) the specific Health Insurer activities, resources and financial supports needed by providers to achieve the targets, and (iii) common standards and procedures governing Health Insurer-primary care provider contractual agreements, such as, for alignment of performance measures and Health Insurer provision of information to practice. Such activities, resources, and financial support may include: the creation of community health teams to support small, independent practices with care management resources, and the deployment of practice coaches to provide technical assistance for primary care practices. The plan, together with any stakeholder comments, shall be submitted to the Commissioner on or before May 1st of each year.

(C) In the event that the Committee's stakeholders are unable to reach agreement on the plan, the Commissioner may require adoption of a suitable plan as a condition of approval of Health Insurers' rates.

(3) Health Insurers shall fund the care transformation plan in accordance with a formula established by the Commissioner that is based upon the Health Insurer's market share and other relevant considerations. In meeting its annual financial obligation, the Health Insurer's insured covered lives shall not bear a financial burden greater than their fair share of expenses that benefit both insured covered lives, and other covered lives whose health plans are administered by the Health Insurer. The Health Insurer's expenses in connection with the budget shall be accounted for as Direct or Indirect Primary Care Expenses, as applicable.

(d) Payment reform.

(1) Population-based contracting. Health Insurers shall take such actions as are necessary to achieve the following population-based contracting targets:

(A) By the end of calendar year 2015, at least 30 percent of insured covered lives shall be subject to a Population-Based Contract with shared savings, ~~or~~ with risk sharing or global capitation.

(B) By the end of calendar year 2016, at least 45 percent of insured covered lives shall be subject to a Population-Based Contract with shared savings, and claims for at least 10 percent of insured covered lives shall be paid under a Population-Based Contract with risk sharing.

(C) By the end of calendar year 2017, at least 60 percent of insured covered lives shall be subject to a Population-Based Contract with shared savings, and claims for at least 20 percent of insured covered lives shall be paid under a Population-Based Contract with risk sharing.

(D) A Health Insurer shall not enter into a risk sharing or global capitation contract unless the Health Insurer has determined, in accordance with standard operating procedures established in its rating manuals, that the provider organization entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provision of covered services to members attributable to the provider organization. At the reasonable request of the provider organization, the Health Insurer shall maintain the confidentiality of information which the Health Insurer requests to make its determination. The Health Insurer shall periodically review the provider organization's continuing ability to assume such responsibilities. The Health Insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. In making its determination, the Health Insurer shall evaluate:

(i) The provider organization's assets, liabilities, reserves, sources of working capital, other sources of financial support, and projections for the results of operations for the succeeding three years.

(ii) The provider organization's financial plan, including anticipated timing of income and expenses associated with the risk sharing contract, a plan to establish and maintain sufficient financial resources (including insurance or other agreements) to

protect against potential losses, mechanisms to monitor the financial condition of any subcontracting entities whose performance may impact the provider organization's risk sharing or global capitation payment results.

(iii) The provider organization's utilization plan, including suitable monitoring of in-patient and outpatient utilization associated with the risk sharing or global capitation contract.

(iv) An actuarial certification, prepared after examining the terms of the provider organization's risk sharing or global capitation contracts, as to whether such contracts (including procedural controls within the contracts) may adversely affect the financial solvency of the provider organization.

(2) Alternative payment methodologies.

(A) The purpose of this Subdivision (d)(2) is to significantly reduce fee-for-service as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payments with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.

(B) Health Insurers shall increase annually their use of nationally recognized, alternative payment methodologies payments for hospital services, medical and surgical services, and primary care services in accordance with a schedule filed by the Health Insurer and approved by the Commissioner during the annual rate review process.

(C) The Commissioner shall convene an Alternative Payment Methodology Committee by February 1, 2015, and by January 1 of each year thereafter, composed of stakeholders designated by the Commissioner. The Committee shall be charged with developing a target and a target date for increasing the use of alternative payment methodologies submitted for the Commissioner's approval by May 1, 2015, and an annual alternative payment methodology plan for achieving the target. The Committee that convenes on January 1, 2016 shall be tasked with developing an alternative payment plan that specifically addresses medical and surgical specialty professional providers.

(D) The alternative payment methodology plan shall recommend, for approval by the Commissioner: (i) annual targets prior to achieving the ultimate target, and (ii) the type of payments that should be considered alternative methodology payments (such as bundled payments, prospective payments, and pay-for-performance payments). The plan, together with any stakeholder comments, shall be submitted to the Commissioner on or before May 1st of each year.

(E) In the event that the Committee's stakeholders are unable to reach agreement on the plan, the Commissioner may require adoption of a suitable plan as a condition of approval of Health Insurers' rates.

(3) Hospital contracts.

(A) Each Health Insurer shall include in its hospital contracts the terms required by this Subsection (d)(3).

(B) This Subsection (d)(3) shall apply to contracts between a Health Insurer and a hospital licensed in Rhode Island which are entered into, or which expire after July

1, 2015, or which would expire but for the amendment or renewal of the contract (whether the renewal is effective pursuant to the terms of a previously executed contract, or otherwise).

(C) Hospital contracts shall utilize unit of service payment methodologies for both inpatient and outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee-for-service. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, institutional or global capitation payments, or case rates.

(D) Hospital contracts shall include a quality incentive program.

(i) The quality incentive program shall include payment for attaining or exceeding mutually agreed-to, sufficiently challenging performance levels for all or a subset of measures in the CMS Hospital Value-Based Purchasing Program for Medicare.

(ii) The quality incentive program shall include measurement of the effectiveness of the "transitions of care" element of the program, as developed by the designated Medicare Quality Improvement Organization.

(iv) The contract's quality incentive program may also include one or more of the following: (I) other nationally accepted clinical quality, service quality, or efficiency-based measures; (II) mutually agreed upon metrics of clinical quality that may have no clear precedent nationally, and (III) mutually agreed upon clinical quality improvement activities that support new models of care coordination. The measures, performance levels, payment levels, and payment mechanisms must be articulated in the contract.

(v) Incentive payments will not be due and payable until the incentive measures have been met or achieved by the hospital. A Health Insurer may make interim payments in the event that interim measures of performance have been met; provided that the interim payments must be commensurate with the achievement of the interim measures; and provided further that a final settlement may only occur after the measurement period; and provided further that if the annual measures of performance have not been achieved, the hospital shall be required to remit unearned interim payments back to the Health Insurer. Quality incentive payments shall not carry forward to base payments in succeeding years.

(E) Hospital contracts shall include a provision that agrees on rates, and quality incentive payments for each contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if either:

(i) the average rate increase, including estimated quality incentive payments, is greater than the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase for the Northeast Region, or

(ii) less than 50% of the average rate increase is for expected quality incentive payments.

(F) Hospital contracts shall include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and

eligibility verification processes, and identify commitments on the part of each, and that require the parties to actively participate in the Commissioner's Administrative Simplification Work Group.

(G) Hospital contracts shall include terms that relinquish the right of either party to contest the public release, by state officials or the parties to the contract of the provisions of the contract demonstrating compliance with the requirements of this Subsection (d)(3); provided that the Health Insurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

(4) Population-based contracts.

(A) This Subsection (d)(4) applies to Population-Based Contracts between an Integrated System of Care and a Health Insurer which are entered into, or expire after July 1, 2015, or which would expire but for the amendment or renewal of the contract (whether the renewal is effective pursuant to the terms of a previously executed contract, or otherwise).

(B) Population-Based Contracts shall include a provision that agrees on a budget for each contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase, plus one percent, for the Northeast Region.

(C) Population-Based Contracts shall include terms that relinquish the right of any party to contest the public release, by state officials or the parties to the contract, of the provisions of the contract demonstrating compliance with the requirements of this Subsection (d)(4); provided that the Health Insurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality.

(5) Nothing in Subdivisions (d)(3) or (4) is intended to require that the Health Insurer must contract with all hospitals and providers licensed in Rhode Island. Consistent with statutes administered by the Department of Health, Health Insurers must demonstrate the adequacy of their hospital and provider network.

(e)(1) The Commissioner, upon petition by a Health Insurer for good cause shown, or in his or her discretion as necessary to carry out the purposes of the laws and regulations administered by the Office, may modify or waive one or more of the requirements of this Section. Any such modifications shall be considered and made during the formal process of the Commissioner's review and approval of health insurance rates filed by the Health Insurer.

(2)(A) On or before January 1 of each year the Commissioner shall solicit comments from stakeholders, and issue formal guidance concerning whether the population-based contracting targets established in Subsection (d)(1)(A-C), the population-based contract budget limits established in Subsection (d)(4)(B), the care

transformation requirements established in Subdivision (c)(1), or the alternative payment requirements established in Subdivision (d)(2)(B) should be modified:

(i) to create an effective incentive for hospitals and providers to participate in care transformation, population-based contracts and alternative payment arrangements;  
or

(ii) to 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.

(B) A Health Insurer shall not be held accountable for a violation of the population-based contracting targets established in Subsection (d)(1)(A-C), the population-based budget limit established in Subdivision (d)(4)(B), the care transformation requirements established in Subdivision (c)(1), or the alternative payment requirements established in Subdivision (d)(2)(B) if the Health Insurer demonstrates to the satisfaction of the Commissioner that compliance with any of these requirements was not possible, notwithstanding the Health Insurer's good faith and reasonable efforts. The Health Insurer shall notify the Commissioner and request a waiver under Subdivision (e)(1), if desired, as soon as any such circumstances arise.

(f) Data collection and evaluation.

(1) On or before 15 days following the end of each quarter, each Health Insurer shall submit to the Commissioner, in a format approved by the Commissioner, a Primary Care Spend Report, a Care Transformation Report, and a Payment Reform Report, including such data as is necessary to monitor and evaluate the provisions of this Section.

(2) On or before October 1 and annually thereafter, the Office shall present to the Health Insurance Advisory Council a monitoring report describing the status of progress in implementing the Affordability Standards.

(3) During calendar year 2018, the Office shall conduct a comprehensive evaluation of the Affordability Standards, together with recommendations for achieving the health care quality and affordability goals of the Office. Following completion of the comprehensive evaluation, the Commissioner shall request the Health Insurance Advisory Council to review the evaluation and make recommendations to the Commissioner for any revisions to the Affordability Standards.

(4) Health Insurers shall provide to the Office, in a timely manner and in the format requested by the Commissioner, such data as the Commissioner determines is necessary to evaluate the Affordability Standards, to monitor compliance with the Affordability Standards established in this Section 10, and to evaluate and monitor the activities necessary to implement the State Innovation Models Grant, if awarded to Rhode Island by the federal Centers for Medicare and Medicaid Services. Such data may include any hospital or provider reimbursement contract, and any data relating to a hospital's attainment of quality and other performance-based measures as specified in quality incentive programs referenced in Subsections (d)(3)(E) and (d)(3)(F).

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Section 11 Administrative Simplification

(a) Administrative Simplification Task Force.

(1) An Administrative Simplification Task Force is established to make recommendations to the Commissioner for streamlining health care administration so as to be more cost-effective, and less time-consuming for hospitals, providers, consumers, and insurers, and to carry out the purposes of RI Gen. Laws section 42-14.5-3(h). The Commissioner shall appoint as members of the Task Force ~~members~~ representatives of hospitals, physician practices, community behavioral health organizations, each health insurer, and other affected entities. The Task force shall also include at least one designee each from the Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The Chair or Co-Chairs of the Task Force shall be selected annually by its members.

(2) An annual work plan for the Task Force shall be established. By September 1 of each year, members of the Task Force may propose issues for the Task Force to review, together with such data and analysis that demonstrates the need to address the issue. If the Task Force cannot agree on an annual work plan, the Commissioner shall adopt an annual work plan. The Taskforce will meet during September, October and November to make its recommendations to the Commissioner for resolving issues identified in the work plan no later than December 31 of each year. If the Task Force agrees on recommendations for resolving the identified issues, those recommendations will be submitted to the Commissioner for her or his consideration. If the Task force cannot agree on recommendations, a report will be submitted to the Commissioner on the Task Force's activities, together with comments by members concerning the identified issues. The Commissioner may adopt such regulations as are necessary to carry out the purposes of this section, and the purposes of RI Gen. Laws section 42-14.5-3(h).

(c) Retroactive terminations.

(1) The purpose of this Subsection is to reduce administrative burdens as well as the associated costs in connection with the practice of retroactive terminations, create an incentive for efficiencies among stakeholders for timeliness of notices of termination, and establish an equitable balance of financial liability among health insurers, employers and enrollees in light of the unavailability of real time, accurate eligibility information.

(2) Health insurers shall cease the administrative process of seeking recoupment of payment from providers in the case of retroactive terminations.

(3) Health insurers may include the reasonable cost of retroactive terminations into their filed rates. Health insurers may establish reasonable contractual requirements with providers with regard to eligibility checks at the time services are provided. In addition, health insurers include reasonable adjustments attributable to the insurer's financial burden with respect to retroactive terminations with its employer groups, so long as the process does not include recoupment of payments from providers in the event of retroactive termination.

(d) Coordination of benefits.



(1) The purpose of this Subsection is to improve on the accuracy and timeliness of information when an enrollee is covered by more than one insurer, and to communicate to affected parties which insurer's coverage is primary.

(2) Health insurers shall (i) accept a common coordination of benefits ("COB") form approved by the Commissioner; (ii) submit to the Commissioner for approval a procedure to inform contracted providers of a manual and electronic use of the common COB form in provider settings; (iii) not alter the common COB form, except for use internally by the insurer, or on the insurer's website, and in these excepted instances only the insurer's name and contact information may be added to the form; (iv) accept the common COB form submitted by the provider on behalf of patient; and (v) include a flag within the insurance eligibility look-up section of its website indicating the last update of an enrollee's COB information. Health insurers may continue to use their own COB form as part of its annual member survey.

(3) Health insurers shall participate in a centralized registry for coverage information designated by the Commissioner by January 1, 2016. If the Centers for Medicare and Medicaid Services designates a centralized registry, health insurers shall participate in the CMS designated registry no later than one calendar year from the date of use of the designated registry by Medicare.

(4) Health insurers shall establish written standards and procedures to notify providers of all eligibility determinations electronically or telephonic at the time eligibility determination is requested by the provider.

(e) Appeals of "timely filing" denials.

(1) This Subsection is intended to permit a provider to appeal the denial of a claim for failure to file claim within the time period provided for in the participation agreement when the provider exercised due diligence in submitting the claim in a timely manner, or when the claim is filed late due to no fault of the provider.

(2) Health insurers shall accept a provider appeal for failure to meet timely claim filing requirement so long as the appeal is submitted to the carrier within 180 of date that the provider received proof that the carrier was the primary carrier.

(3) Health insurers shall not deny a claim based on failure to meet timely filing requirements in the event that the provider submits all of the following documentation:

(A) A copy of the timely filing denial;

(B) Written documentation that the provider billed another plan or the patient within at least 90 days of the date of service;

(C) If provider billed another plan, an electronic remittance advice, explanation of benefits or other communication from the plan confirming the claim was denied and not paid or inappropriate payment was returned;

(D) If provider billed the patient, acceptable documentation may include: (i) benefit determination documents from another carrier, (ii) a copy of provider's billing system information documenting proof of an original carrier claim submission, (iii) a patient billing statement that includes initial claim send date and the date of service, or (iv) documentation as to exact date the provider was notified of member's coverage

under carrier, who notified the provider, how the provider was notified and a brief statement as to why the provider did not initially know the patient was not covered by carrier. Practice management and billing system information can be used as supportive documentation for these purposes.

(4)(A) Health insurers shall notify providers that upon submission of the information required by Subdivision (3), the health insurer shall not deny the claim due to the failure to file the claim in a timely manner. Nothing in this Subsection precludes the denial of a claim for other reasons unrelated to the timeliness of filing the claim.

(B) Health insurers shall utilize a standardized appeal checklist approved by the Commissioner when informing providers of a timely filing denial and what needs to be submitted to appeal that denial. The checklist and appeal submissions shall be made available for both manual and electronic processing.

(f) Medical records management.

(1) The purpose of this Subsection is to maintain the confidentiality of patient information during the process of transmittal of medical records between providers and health insurers, and to reduce the administrative burden of both the providers and carriers with regard to medical record submissions.

(2) Health insurers shall comply with all state and federal laws and regulations relating to requests for written clinical and medical record information from patients or providers.

(3) Health insurer requests for medical records shall specify:

(A) What medical record information is being requested;

(B) Why the medical record information being requested meets 'need to know' requirements; and

(C) Where the medical record is to be sent via mailing addresses, fax or electronically.

(4) Health insurers shall establish a mechanism to handle the clinical information once received from the provider. The mechanism shall provide for the verification of the receipt of the medical records when a provider requests such verification.

(5) Upon a provider's request, the health insurer to notify the provider of any mis-sent or mis-addressed records. In such events the health insurer shall destroy the mis-sent of mis-addressed records, and so notify the provider.

(6) Health insurers shall post on their website, and in communications with providers, a clear listing of contact information, including mailing address, telephone number, fax number, email, as to where the medical record is to be sent. If more than one address is posted, an explanation shall be provided as to what types of medical record information is to be sent to which address.

### **Section 12 — Price Disclosure**

(a) The purpose of this Section is to empower consumers who are enrollees in a health insurance plan to make cost effective decisions concerning their health care, and to

enable providers to make cost-effective treatment decisions on behalf of their patients who are enrollees of a health insurance plan, including referral and care coordination decisions.

(b) A health insurer shall not enforce a provision in any participating provider agreement which purports to obligate the health insurer or health care provider to keep confidential price information requested by a health care provider for the purpose of making cost-effective clinical referrals, and for the purpose of making other care coordination or treatment decisions on behalf of their patients who are enrollees in the health benefit plan of the health insurer.

(c) At the request of a health care provider acting on behalf of an enrollee-patient, a health insurer shall disclose in a timely manner to the health care provider such price information as the provider determines is necessary to make cost-effective treatment decisions on behalf of their patients, including clinical referrals, care coordination, and other treatment decisions.

(d) A health insurer may adopt reasonable policies and procedures designed to limit the disclosure of price information for unauthorized purposes.

(e) Each health insurer shall file for the Commissioner's approval its Comprehensive Price Transparency Plan. A Comprehensive Price Transparency Plan shall empower consumers and health care providers to make informed and cost-effective health care decisions. The Plan shall:

(1) identify the health care services, products and supplies subject to price disclosure under the Plan, including but not limited to hospital in-patient and out-patient services, physician services, other health care provider services, medical imaging services, laboratory services, prescription drug prices, durable medical equipment, and medical supplies;

(2) identify the health services, products and supplies, if any, that are not subject to price disclosure under the Plan, a reasonable basis for not including those services, products and supplies within the Plan, and a time table for including those services, products and supplies in the Plan; and

(3) disclose price information with respect to services reimbursed on a fee-for service basis, as well as services reimbursed by alternative reimbursement mechanisms.

#### **Section 103 Severability**

If any section, term, or provision of this regulation is adjudged invalid for any reason, that judgment shall not affect, impair, or invalidate any remaining section, term, or provision, which shall remain in full force and effect.

#### **Section 14 Construction**

- (a) This regulation shall be liberally construed to give full effect to the purposes stated in R.I. Gen. Laws § 42-14.5-2.
- (b) This regulation shall not be interpreted to limit the powers granted the Commissioner by other provisions of the law.

#### **Section 15 Effective Date**

This Regulation shall be effective on the date indicated below, and shall apply to decisions made or actions taken by the Commissioner on and after the effective date of this Regulation.

EFFECTIVE DATE: December 15, 2006

AMENDMENT EFFECTIVE DATE: September 28, 2012.

AMENDMENT EFFECTIVE DATE:

To: Office of the Health Insurance Commissioner  
Attn: Herbert W. Olson, Legal Counsel  
(Electronic submission to: [HealthInsInquiry@ohic.ri.gov](mailto:HealthInsInquiry@ohic.ri.gov))

From: Al Kurose, MD MBA FACP  
President and CEO, Coastal Medical

Re: Public Comment on Proposed Amendment to OHIC Regulation 2

### **Context and Comments in General**

Coastal strongly supports the work that OHIC has done to try to improve the affordability of health care in Rhode Island. We agree that a high performing system of integrated primary care must be the foundation for Rhode Island's high performing health care delivery system of the future.

At Coastal, we recognize that the OHIC affordability standards have played a major role over the last several years in supporting the evolution of our own organization to become a primary care driven ACO that has demonstrably improved the access to care, quality of care, patient experience of care, and the total cost of care for the populations of patients we serve.

Coastal was the first ACO to form in RI, and we began our multi-payer approach to accountable care with our first shared savings contract with BCBSRI in January of 2012. Our portfolio of shared savings contracts based on total cost of care now includes a total of six separate commercial, Medicare Advantage, and "original" Medicare populations. Coastal was amongst the just 25% of all Medicare Shared Savings Program ACO's nationwide that earned a shared savings payment in the first round of the program. Total cost of care for our population of 10,000 original Medicare patients over the first 18 months of the program was 5.4% below the total cost benchmark set for us by CMS.

All of our current relationships and contracts with BCBSRI, United, and Tufts are all aligned to support pursuit of better care and more cost efficient care for the populations of members we serve. We recognize the importance of the support from these insurers of our work in population health management.

### **Specific Concern Regarding the Proposed Cap on Annual Budget Increases for ACO's**

The portion of the proposed regulation about which we are most concerned reads as follows:

Population-Based Contracts shall include a provision that agrees on a budget for each contract year, such that review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase, plus one percent, for the Northeast Region.

Our concerns with the proposed regulation are the following:

1. A “CPI plus one” cap on ACO budgets *in the absence of sufficient regulation of other stakeholders in the care delivery system* will significantly and disproportionately disadvantage ACO’s managing total cost of care. The budget increase caps already in place for hospitals are noted, but inpatient and outpatient hospital costs comprise only ~40% of commercial total cost of care budgets. If specialty care, pharmacy, diagnostic testing, home care, nursing home care, DME and other sectors are unregulated, then ACO’s cannot be expected to meet such a stringent budget growth cap. By comparison, the “adjusted benchmark” budget growth targets in the MSSP make more sense from an economic standpoint because Medicare controls prices taken by *all* providers across the health care delivery system.
2. The proposed cap would have the unintended consequence of removing any shared savings opportunity for ACO’s that are controlling total cost of care significantly better than the rest of the market, but working in a market where cost trend is significantly above CPI plus one. I expect our performance under the Coastal/BCBSRI shared savings contract for 2014 will provide a demonstration instance in which this unintended consequence would occur if the proposed regulation were to be enacted.
3. Based on the first two concerns above, if the proposed regulation were enacted, Coastal would be forced to immediately scale back planned clinical initiatives which we expect will further improve service to patients and lower costs.
4. ACO’s in general are new entrants to the health care market. OHIC, CMS, and many other thought leaders want them to succeed, because the ACO business model is built on improving quality and lowering costs. The MSSP provides an example of how difficult it is to achieve early success as an ACO. This is a nascent industry with many entrants on unsure financial footing. There is a risk that overly stringent regulation could extinguish a promising new movement in health care, both locally and nationally.
5. We conclude that a fully informed, fully rational group of providers in RI considering becoming an ACO would not do so if this regulation were enacted.

### **Other Comments**

We strongly support the proposals to convene a Care Transformation Advisory Committee and an Alternate Payment Methodology Committee.

We recommend a period of observation before capping ACO total cost of care budget increases in RI.

Respectfully submitted, 12/5/14



1210 Pontiac Avenue Cranston, RI 02920 CALL 401.270.0101 800.464.3399 (in RI) FAX 401.270.7049 VISIT [www.ripin.org](http://www.ripin.org)

Kathleen C. Hittner, Commissioner  
Office of Health Insurance Commissioner  
1511 Pontiac Avenue  
Cranston RI, 02920

RE: Proposed Amendment to Regulation 2

The Rhode Island Parent Information Network (RIPIN) provides information, support, and training to help all Rhode Islanders become their own best advocate at school, in healthcare and in all areas of life. Many of our programs and projects provide RIPIN with a unique consumer perspective and experience as well as utilization of health services and insurance. For this reason RIPIN would like to take the opportunity to propose recommendations and considerations from the consumer perspective.

The proposed recommendation within the Affordability Standards address Primary Care Spend, Patient Centered Medical Home Expansion (PCMH), Current Care, Payment Reform and Data Collection and Evaluation. RIPIN supports all the proposed policies within the Affordability Standard. The proposed standards are aimed to achieving affordable health insurance and an improved health delivery system. While RIPIN is in strong support of ensuring Rhode Island advance these important policies, we remain concerned that many proposals within the standards could have unintended consequences to the consumer.

PCMH expansion is a vital element of reforming our health delivery system, and ensuring the ability to advance this model, is critical. Rhode Island has made significant gains in the PCMH arena in the last seven years and continuing this is advancement is vital to achieve an 80% target of residents receiving care in a PCMH. Insurers must continue to promote and provide adequate resources to the practices that have achieved this level to maintain this level of activity while also supporting those who are aiming to achieve this standard. Consumers benefit tremendously from PCMH care and have continued to show improved satisfaction and improved care coordination.

Additionally, it has been recommended to allow Advanced Primary Care Practices (APCP) to also be included in health insurer's contractual incentives as well as be included within the target of the 80% goal of residents receiving care in PCMH practices. While these remains unclear as to the exact standards APCP would achieve, it is of concern lowering the PCMH standard will not achieve the desired outcome of an improved health delivery system for the consumer. Further, this may have an adverse impact on socially and economically disadvantaged communities should the APCP not provide the level of care and care coordination that the PCMH practices are able to provide. Careful consideration should be given to evaluating this

proposed recommendation to ensure this would not have the unintended consequence of diverting resources to lower quality primary care.

RIPIN currently operated the Rhode Island Consumer Health Insurance Consumer Helpline (RIREACH) helpline. RIREACH has expert knowledge of the extraordinary challenges consumers are facing when attempting to understand and access health insurance coverage and benefit utilization. For this reason, RIPIN would strongly recommend the Affordability Standards be utilized as a tool to ensure the consumer interest is protected, and affordability is achieved for the consumer. Currently, consumers have extraordinary difficulty accessing and utilizing their health insurance benefits and often find the insurance costs far exceed their financial means. As the development of Alternative Payment Methodologies continues to develop, RIPIN would urge the OHIC to include consumer advocates presence during such developments, as the consumer is the ultimate purchaser within the health delivery system.

RIPIN applauds the OHIC for their long standing record and strong effort to improve our health delivery system and promote policies that will enable our insurers and providers to build a system of care that is affordable and meets the needs of the consumer.

Sincerely,

Tina Spears  
Government Relations Director





## Lifespan

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**Marc A. Proto, MBA, FHFMA**  
*Vice President of  
Contracting*

December 3, 2014

Dr. Kathleen C. Hittner  
Health Insurance Commission  
Office of the Health Insurance Commissioner  
1511 Pontiac Ave. Bldg 9-1  
Cranston, RI 02920

RE: Proposed Amendments to Regulation 2; the Affordability Standards

Dear Commissioner Hittner:

We write to provide comments on the Office of the Health Insurance Commissioner's (OHIC) proposed amendments to the Affordability Standards (Amended Regulation 2). We acknowledge we are in a time of unprecedented change and as the state's largest healthcare system and primary safety net provider; we are pleased to be an active participant in the ongoing efforts to reform the current system.

The proposed amendments to Regulation 2 represent a considerable shift in emphasis, employing new tactics to direct the payer-provider relationship. This is of interest to us, especially as traditional roles of both types of organizations are changing. Lifespan has concerns with the proposed hospital contract rate review contained in Amended Regulation 2. Amended Regulation 2 requires OHIC to give prior approval for rate increases that are greater than the CPI, less the food and energy (CPI-Urban) for the Northeast Region or less than 50 percent of the average rate increase is for expected quality incentive payments. Currently, only two (2) states employ rate caps in systems different than Rhode Island. The selection of the CPI-Urban index is not an index utilized by CMS. Moreover, the statewide picture is more accurately captured by the gross state product (GSP), a path that seems to be the preferred approach by a growing number of states. It seems more prudent that a more fulsome discussion take place about various approaches before a definitive decision is made in this regard. This is especially important as we think it prudent to guard against unintended consequences on the hospital sector as we adopt additional limitations on contracting flexibility. Finally, it is unclear what process, if any, OHIC will utilize for review of rates contained in hospital contracts with both the frequency and ever-changing nature of the CPI-Urban. This can result in uncertainty in contracting and impact contract terms intended to provide business stability.

Lifespan supports the concept of transparency relating to pricing disclosure. However, as it is contained in Amended Regulation 2, such proposed transparency will be subject to each individual health insurer with regard to how they disclose pricing. Lifespan believes that such a process should be standardized or, at the very least, made as consistent as possible. In addition, pricing disclosure should also include Massachusetts and Connecticut providers who impact the medical expense ratio. We think this is a crucial issue to understand, as out of state spending is beyond the regulatory reach of the state and therefore in-state hospital bare the full impact of cost containment efforts.

Another issue contained in Amended Regulation 2 that Lifespan believes requires more discussion among stakeholders is the proposal related to direct insurer funding to primary care and the overall goal to increase said funding. Again, while Lifespan agrees with the general purpose, we are concerned about the physician network implication for providers, specifically those that are part of a healthcare system.

Amended Regulation 2 also proposes an aggressive approach to transition to alternative risk models, i.e., alternative payment methodologies, by 2016. Lifespan recognizes the need for healthcare transformation to move away from the fee-for-service payment models and has been on the forefront of these efforts; however, Amended Regulation 2 seemingly institutes a goal independent of other statewide efforts, such as the SIM Grant and ACOs. Specifically, Amended Regulation 2 contains no metric for success and, accordingly, the result will be regulations with no means to define or measure success. While the transition is not immediate since the Amended Regulation 2 impacts new contracts after 2016, such a timeframe is short and we are unaware of any discussion that considered the unintended consequences.

Further administrative simplification is also necessary in Amended Regulation 2. While it does provide for an Administrative Simplification Task Force, requiring insurers to accept a common coordination of benefits and participation in a centralized registry, these do not address the ongoing added administrative burdens already imposed (or being imposed) on providers as subjective policies with no clear medical criteria, process, appeal process and/or dispute resolution process. Lifespan is concerned that these payer policies, further supported by Amended Regulation 2, insert payers into the exclusive province of providers, particularly hospitals, which remain solely responsible for exercising independent judgment in clinical decisions regarding all aspects of patient care. Since these administrative burdens also impact the total cost of care, Lifespan believes that addressing them within Amended Regulation 2 is prudent.

Lifespan is also concerned about the expansion of authority granted to the Office of the Health Insurance Commissioner as well as the expanded role of CSIs. For example, Section 10(a)(1)(A) creates a percent spend on annual medical expenses, but subsection (B) then allows the Commissioner to change this to "achieve the purpose of supporting primary care as an affordability strategy." Similar broad authority is contained in subsection (e) that allows the Commissioner to modify or waive one or more of the requirements of the Amended Regulation 2 for cause shown or "in his or her discretion as necessary to carry out the purposes of the laws and regulations administered by the Office." Lifespan believes that, overall, such language creates role confusion and inserts OHIC into various hospital contracts by

claiming certain contract provisions impact the Affordability Standards. Moreover, regulations must not be vague and capricious to ensure, *inter alia*, that those regulated can clearly understand the standards and rules they are required to follow.

Such expansive regulations should not be rushed through with strict adherence to the shortest APA timeframes possible. Accordingly, Lifespan respectfully urges OHIC to delay implementation of Amended Regulation 2 for the reasons stated above.

Sincerely,



**Marc A. Proto, MBA, FHFMA**  
**Vice President of Contracting and Payer Relations**  
**Lifespan**

cc: Timothy J. Babineau, MD  
President and Chief Executive Officer

Mark Montella  
Senior Vice President, External and Strategic Affairs

Mamie Wakefield  
Executive Vice President and Chief Financial Officer

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*Philip N. Anderson*  
*Associate General Counsel and Director,*  
*Legal, Compliance and Regulatory Affairs Northeast*

December 10, 2014

Herbert W. Olson, Esq.  
Executive Counsel  
Office of the Health Insurance Commissioner  
1511 Pontiac Ave., Bldg #69, 1st Floor  
Cranston, RI 02920

Re: Proposed Amendments to Regulation 2

Dear Mr. Olson:

Thank you for opportunity to provide additional comments at this time on behalf of UnitedHealthcare of New England, Inc. and UnitedHealthcare Insurance Company (“United”) regarding the proposed amendments to OHIC Regulation 2. I will address our comments in the order in which the proposed amendments are set forth in the Regulation.

### Section 3 – Definitions

The definition of “Direct Primary Care Expenses” limits the definition of such expenses to payments by the “Health Insurance Issuer” directly to a primary care practice for a number of specific categories. We believe the definition should be broadened to include payments to a facility-based or medical group-based Accountable Care Organization (“ACO”) that directly supports a primary care practice, such as providing case managers, hospitalist services or other administrative services. The definition should also be broadened to include infrastructure payments to ACOs that help develop the capacity for these services.

The definition of “Patient Center Medical Home” appears to be limited to primary care practices. We believe the definition should be broadened to include other types of organizations, such as ACOs, that may also function as PCMH or provides direct support for a PCMH.

### Section 9 – Affordable Health Insurance – General

Subsection (d)(iii) provides a threshold of 10,000 covered lives for insurers who are required to employ delivery system reform and payment reform strategies. The definition of covered lives should be further defined as fully-insured covered lives under RI issued policies.

#### Section 10 – Affordable Health Insurance – Affordability Standards

Subsection (a). The definition of covered lives should be further defined as fully-insured covered lives under RI issued policies.

Subsection (b). The regulations should not state that they will be used “ensure” sufficient financial support for primary care providers in Rhode Island. This would be beyond the powers and duties of the Commissioner. The regulation may be enacted to “encourage” such financial support with a goal to achieving the purposes of the Affordability Standards.

Subsection (b)(1)(A). The applicability of payments for administrative expenses of the medical home initiative and health information exchange should be extended beyond 2014 unless the requirement for insurers incurring such payments is discontinued for later years.

Subsection (b)(1)(B). Any reassessment of primary care spend should not result in any increase of the percentages set forth in the preceding subsection. The Commissioner should consult with and get the agreement of the affected carriers on any such reassessments.

Subsection (b)(3). We do not believe the Commissioner has jurisdiction to mandate fully insured payment level applications to self-funded plans and non-commercial plans. Claims payments for these “non-insured members” should not affect the calculation of required payments for fully-insured members. United does not control a self-funded member’s access to covered services and cannot limit the amount of claims it pays on behalf of plan sponsors for these populations.

Subsection (c). We fully support OHIC and the State’s efforts to effect primary care practice transformation. However, the purpose of the regulations should be to “encourage” primary care practice transformation when appropriate, not actually require it in all cases. Practice transformation requires the ability and willingness of providers to participate in any such efforts. Insurers can only encourage transformation through contractual incentives and administrative policies. They cannot transform provider practices on their own. Any target percentage of provider participation should be a goal and not a set requirement (Subsection (c)(1)). Contractual provisions should be permissive and not required. Insurers should retain the flexibility to contract as they deem appropriate for their business objectives and strategies for any specific provider or program (Subsection (c)(1)). The 80 percent “requirement” should be a goal or target and not a requirement (Subsection (c)(2)(A)). The care transformation plan should include

sources of funding other than insurer assessments (Subsections (c)(2)(B) and (c)(3). The primary care practice transformation benefits the community at large and should not be funded solely by carriers. The Commissioner does not have jurisdiction to assess carriers for this purpose absent clear legislative authority.

Subsection (d) – Payment Reform. Any percentages set forth in this section should be described as goals and not requirements as explained above. We assume the term “rating manual” was not intended in Subsection (d)(1)(D). Can we assume OHIC was referring to a contracting standard? The list of items a carrier should review should not be exclusive. A carrier may have additional criteria it uses to determine whether a particular provider is able and willing to participate in such contractual arrangements. Even assuming a provider meets the standards reviewed, that should not obligate the insurer to enter into such an arrangement.

#### Subsection (d)(2) – Alternative payment methodologies

United is supportive of the adoption of alternative payment methodologies to support payment reform. However, United is concerned with the apparent prescriptive approach that OHIC is taking with regard to alternative payment methodologies. Any increase in the use of such contractual arrangements should not be determined by a fixed schedule as determined by a committee of stakeholders or by OHIC. We would have concerns about the makeup and credentials of committee members if they were limited in their depth of understanding about a health insurance business. Given our broad national experience, United believes it is in the best position to determine how and when it as a company should enter into these types of arrangements. All carriers should retain the ability to independently enter into such arrangements as they deem appropriate for their specific business needs and market strategies. United is already well on the path to increase the use of such arrangements and fully understands the value of such arrangements in specific circumstance and with specific providers. Ultimately the increased use of such arrangements will require the capacity and willingness of the providers to participate. As a result United cannot guarantee that it could meet any such targets or goals.

#### Section (d)(3) – Hospital contracts.

United is generally in agreement with the provisions in this Section that incorporate previous rate filing approval conditions and a revised index against which annual hospital rate increases are measured.

#### Section (d)(4) – Population-based contracts.

United has no comments on this Section.

#### Section (e)(2)(B) – health insurer accountability.

This section provides for a safe harbor for health insurers to obtain relief from the requirements for population based contracting targets, population-based budget limit,

care transformation or alternative payment if the health insurer can demonstrate to the Commissioner that it was not “possible” to meet these requirements. The standard should not be whether it was “possible” to meet the standards but whether it was either impossible to meet the standards or not commercially reasonable to meet the standards. Due consideration should be given to the health insurer’s reasonable business and market strategies in any given situation.

#### Section (f) – Data collection and evaluation.

Not having seen the data specifications or reporting template that OHIC may utilize, United can only state that it is willing to provide commercially reasonable requested data that it has already collected in the normal course of its business operations and in a manner that it is currently capable of reporting. Absent further guidance, United does not intend to collect new or additional data to meet data requests under this section. Any data that United deems to be proprietary or a trade secret should be designated as confidential by OHIC to be used for internal OHIC purposes only. United reserves its right to provide further comment and approval for any proposed data specifications or reporting template.

#### Section 11 – Administrative Simplification

United has previously commented to OHIC on retrospective termination as set forth in Subsection (c). Requiring commercial carriers to cease seeking recoupment of payment from providers in the case of retrospective terminations is inconsistent with United’s current process and the process followed in the RI Medicaid Program, The State of RI self-insured account and in the Medicare Program. There should be a consistent approach in all markets in the state, and within state agencies.

Regarding Subsection (e), appeals of “timely filing” denials, providers should not be given a blanket 180 days to submit an appeal of timely filing from the date it received proof that the carrier was the primary carrier. There needs to be a limit on the time to submit such an appeal measured from the date of service. Providers need to follow due diligence in obtaining this information and promptly filing an appeal when they receive it.

Regarding Subsection (f), Medical records management, United has already adopted policies and procedures related to federal and state confidentiality and privacy requirements regarding patient records. United has also already adopted national policies and procedures for the handling of such records. Two areas of concern are the requirements to verify receipt of documents from a provider and notification to the provider that of any mis-sent or mis-addressed records. Given the breadth and size of our national organization we cannot assure that any mis-sent or mis-addressed records will not be sent to areas within our numerous companies or offices of our delegated vendors that will not recognize the documents or be aware of the requirement to notify the provider. We do not systematically send verification of receipt of documents to providers for similar reasons. Such verifications may in fact delay action on the documents before

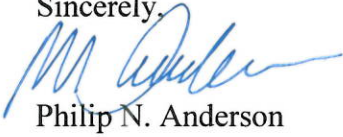
they can be put into the proper channels for processing. It would not be possible for us to alter our national processes in a way that would assure compliance with these requirements.

Section 12 – Price Disclosure

These provisions appear to restate existing OHIC Bulleting language and thus United has no further comments.

Thank you once again for the opportunity to comment. If you have any questions or need clarification on our comments, please feel free to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Philip N. Anderson", is written over the typed name.

Philip N. Anderson

cc. Stephen J. Farrell, CEO



**RECEIVED**

DEC 05 2014

**Health Insurance  
Commissioner**

December 5, 2014

Joseph V. Cavanagh, Jr.  
William R. Landry  
Edmund L. Alves, Jr.  
Stephen J. Reid, Jr.  
Scott T. Spear  
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[www.blishcavlaw.com](http://www.blishcavlaw.com)***By Courier***Herbert W. Olson, Esq.  
Executive Counsel  
Office of the Health Insurance Commissioner  
1511 Pontiac Avenue, Bldg. 39, 1<sup>st</sup> Floor  
Cranston, RI 02920**Re:   Delta Dental of Rhode Island Comments  
      On Proposed Amendments To Regulation 2**

Dear Mr. Olson:

Delta Dental of Rhode Island ("DDRI") hereby respectfully comments on the Proposed Amendments to Regulation 2, as follows:

While Delta Dental of Rhode Island, a non-profit dental service corporation, and Altus Dental Insurance Company, its subsidiary, are clearly covered by the definition of "Health Insurer" in Section 3(f) of the Proposed Amendments, several aspects of the Proposed Amendments relate to matters not applicable to dental benefits coverage without including an explicit exemption for such coverage. For example:

- The "Affordability Standards" in Section 10, and their corresponding delivery system and payment reform strategy requirements, apply to "Health Insurers with at least 10,000 covered lives." (Sec. 10(a)). However, those provisions implicitly apply only to medical coverage, particularly in view of their consistent reference to "primary care practices" as "medical homes" and statutory provisions associated with those terms. (See, R.I. Gen. Laws § 42-14.6 and Regulation 2 definitions). Hence, "Health Insurers with at least 10,000 covered lives" is too broad a coverage provision, and an exclusion for "Health Insurers" that are non-profit dental service corporations, or non-profit optometric service corporations, is in order.

- Similar to the above, Section 10(d)(1)'s "Payment Reforms" requirements purport to apply broadly to "Health Insurers", but its language implicitly applies only to "hospital services, medical services, and surgical services", as opposed to dental services. This is reinforced by the fact that the term "Population Based Contracts" is defined in terms of "medical expenses". There should be a more explicit exclusion for "Health Insurers" that are not medical insurers, or at least a formal clarification from OHIC to that effect.

December 5, 2015

Page 2

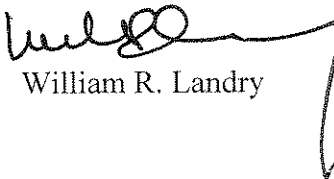
- To the same effect, the “Alternative Payment Methodologies” provisions of Section 10(d)(2) and related “stakeholder group” provisions purport to apply broadly to “Health Insurers”, but are implicitly inapplicable to dental coverage.

- Again, the data collection and quarterly reporting requirements in Section 10(f) purport to apply broadly to “Health Insurers”, but relate entirely to the Affordability and Payment Reform Standards described above that implicitly apply only to medical and surgical coverages.

- Finally, the Medical Records Management” provisions of Section 11(f) purport to apply broadly to “Health Insurers”, but contemplate a logging process – and related administrative processes – that are suitable in the medical/surgical context, but infeasible and impractical from an administrative and cost perspective with respect to the very limited records that are transmitted in connection with dental claims. As is the case with the other medical/surgical related provisions discussed above, there should be an exclusion for Health Insurers that are not medical insurers, or a formal clarification to that effect.

Thank you for the opportunity to provide these comments in behalf of DDRI. Should you wish to discuss them further – or desire any additional information – I trust you will so advise.

Sincerely,



William R. Landry

To: The Office of the Health Insurance Commissioner  
From: The Health Insurance Small Employer Taskforce

Subject: Proposed Revisions to OHIC's Affordability Standards

For decades, small business owners and nonprofit leaders have struggled with health insurance costs rising at an unsustainable rate. We know that the key to curbing these costs is to make systemic changes to the way health care is delivered and paid for.

The Affordability Standards first enacted in 2010 took aim at beginning to make these necessary systemic changes, and we have seen slow but meaningful progress since then. Rhode Island's primary care infrastructure has been significantly enhanced as a result of the Affordability Standards, and important steps toward better integrating care have been taken.

The progress has been incremental, and we must admit that we have yet to see these measures begin to slow premium rate increases to small employers. We still bear an overwhelming burden as we continue to do our part to protect our employees and our companies and organizations. In short, while the original Affordability Standards have been a critical component of health care reform in Rhode Island, the pace of that progress remains altogether too slow from the perspective of small business owners and nonprofit directors.

However, we are encouraged by the proposed revisions to the Affordability Standards and hopeful that they will accelerate the Office of the Health Insurance Commissioner's efforts to bend the cost curve for small group health insurance purchasers. The clear target deadlines for increasing the number of covered lives subject to population-based contracts shows a commitment on the part of the Commissioner to move away from the flawed incentives of the traditional fee-for-service model. Just as encouraging is the proposed requirement to tie future rate increases in hospital contracting and population-based contracting conditions to the defined benchmark of CPI-Urban less Food and Energy for the Northeast Region.

We also applaud the Commissioner and OHIC staff for their continued commitment to stakeholder engagement and to an open, transparent and accessible process, both in the process of developing these new standards and within these proposed revisions themselves.

These Standards, however, are only as effective as OHIC's enforcement of them. Therefore we call on the Commissioner and her staff to continue to aggressively enforce the conditions laid out within these new Affordability Standards. OHIC must hold insurance carriers accountable to these conditions and regulations, and we believe it is within OHIC's authority and mandate to do so.

The proposed revisions to the Affordability Standards are bold, but the goals outlined are achievable. We fully support the objectives of these revisions.

Sincerely,

Mark Gray, Coordinator

On behalf of the Health Insurance Small Employer Taskforce

Office of the Health Insurance Commissioner  
1511 Pontiac Ave, Building 69-1  
Cranston, RI 02920  
Attention Herbert W. Olson, Legal Counsel

Re: Proposed Amendments to Regulation 2

Dear Mr. Olson,

I am writing on behalf of America's Health Insurance Plans (AHIP) to express concerns that several of our members have raised with proposed changes in Regulation 2. AHIP is the national trade association representing the health insurance industry. AHIP's member companies provide health and supplemental benefits to more than 200 million Americans through employer sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

Our specific comments are below:

Section 11 (d)(2)(i) requires the use of a standardized COB form. Our members would appreciate the opportunity to review the form that the Commissioner develops prior to its implementation.

Section 11 (d)(2)(v) would require carriers to include a flag within the insurance eligibility look-up section of its website indicating the last update of an enrollee's COB information. Several of our members expressed concern about the cost and commitment of already stretched resources that this requirement would create. What is the timeframe for implementation of this requirement?

Section 11 (d)(3) requires participation in a centralized registry by January 1, 2016 or, in the alternative, a CMS designated registry. A number of our national plans already participate in the CAQH COB Smart initiative, which is a national registry and those carriers pay fees in order to get the information available in that registry. We would hope that participation in that program would be an acceptable alternative to a Rhode Island specific registry.

Section 11 (f)(3)(B) states that health insurer requests for medical records would need to specify the reason such medical records are being requested on a "need to know" basis. Will the final Regulation define the meaning of "need to know"? Is this requirement included in the proposed Regulation to comply with HIPAA?

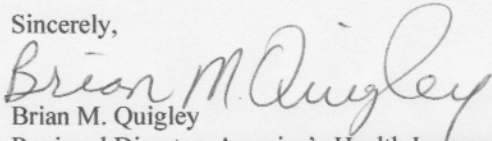
Section 11 (f)(6) requires health insurers to 'post on their website, and in communications with providers, a clear listing of contact information, including mailing address, telephone number, fax number, email, as to where the medical record is to be sent. If more than one address is posted, an explanation shall be provided as to what types of medical record information is to be sent to which address.' Carrier letters to providers requesting additional information always specify where that additional information should be sent. However, the letters do not include all of the contact information required in the proposed Regulation. We do not see the need to have the general listings of contact information required by this section when the specific request will contain the appropriate contact information.

Carriers have concerns with posting contact information to an external website along with the required explanation as to what types of medical records should be sent to the various

addresses. Many different departments request medical records for various purposes. This requirement may open insurers up to misdirected mailings, if the provider relies solely on the web contact information rather than relying on the contact information contained in the request letter.

Thank you for your consideration of our comments.

Sincerely,

A handwritten signature in cursive script that reads "Brian M. Quigley". The signature is written in dark ink and is positioned above the printed name.

Brian M. Quigley

Regional Director, America's Health Insurance Plans.

[bquigley@ahip.org](mailto:bquigley@ahip.org) 860-533-9393

December 4, 2014

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

Dear Dr. Hittner:

The Hospital Association of Rhode Island (HARI) and its members applaud the efforts of the Office of the Health Insurance Commissioner (OHIC) in striving to transform the State's health care delivery system and focus on important areas such as primary care. Our members strongly support the current efforts to migrate the system away from one focused on fee-for-service toward more patient-centered care and payment models. The current proposed amendments to OHIC Regulation 2 – Powers and Duties of the Office of the Health Insurance Commissioner focus primarily on two areas: affordability standards and administrative simplification. HARI strongly supports the proposed administrative simplification changes but would like to express some concerns with regard to the proposed affordability standards.

Hospitals are currently transforming health care in many ways at their facilities and through the exploration of different contractual arrangements with payers. With respect to the proposed affordability standard regulations, our members encourage alignment and/or coordination with the current diverse initiatives of hospitals, payers and other state agencies. However, our members have concerns with the potential for conflict among the other health care reform efforts currently underway in Rhode Island, such as the SIM grant application, Medicaid waiver renewals, HealthSource RI, Health Care Reform Commission, CurrentCare, and the Health Care Planning and Accountability Advisory Council. We are further concerned about possible unintended adverse financial burdens on patients and inflexible financial standards that do not reflect the diversity of providers.

As Rhode Island transforms health care, it is critical to ensure input from all areas of the provider community and recognize the impacts of payment reductions in recent years and limited investments in the future of health care. Our members are concerned that the proposed regulations will further limit hospital rate increases for commercial insurance, which have significantly declined in past years, particularly the change to using CPI-U instead of the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index plus 1%. The current CMS index, at approximately 2.6% plus 1%, would allow hospitals to obtain a very reasonable increase of 3.6% with at least 50% dedicated to quality. The CPI-U less food and energy for the Northeast region appears to be currently at 1.6%. This would

result in a more than 50% reduction in annual increases to hospitals. While we are supportive of transforming the delivery system and addressing the cost of health care, this type of limited increase is not sufficient to invest in our hospitals and ensure delivery system reforms are met.

A minimal increase, with 50% required to be based on quality alone, leaves facilities very little room to offset any operational expense increases (such as health insurance). There is also concern that the 50% will go to contingent quality alone and not be added to the base. Additionally, such a minimal increase comes at a time when Medicaid and Medicaid managed care rates have been frozen for several years, uncompensated care monies have been redirected from hospitals to address state budget difficulties, and Medicare has provided hospitals no increase or reductions under the Affordable Care Act. This current climate has resulted in the only increases in revenues to hospitals coming from commercial insurers. With the proposed amendments, the estimated increase is 1.6%, and at about 30% of a hospital's payer mix, the overall increase in revenue for hospitals will be about a 0.5% each year. The amount hospitals write off as bad debt due to patient financial liability exceeds this increase. Such changes could adversely impact already financially fragile hospitals and key health care delivery system components, causing a shift away from focusing investment on transforming health care. If we want to achieve delivery system reform, job growth and maintain the economic impact of hospitals, then we must invest in them. Our members encourage further discussion on this change and collaboration on initiatives to reduce expenses, rather than just price.

The proposed regulations also promote extensive conversion of medical practices to patient-centered medical homes (PCMHs) – targeting 80% in upcoming years. While our members strongly support the increased use of PCMHs and strong primary care access, the effectiveness of such an approach has yet to be globally demonstrated with local results showing limited cost reductions. Of additional concern is the ability of the individual provider market to meet the standards, enhance their care infrastructure through investment (such as electronic medical records, care management staff, etc.), and weather the financial risks of global budget arrangements. While our members embrace focusing more on population health and exploring more risk-sharing arrangements, the proposed regulations' fixed percentages of global budget contracts and yearly risk-based contract targets, may not adequately provide the flexibility providers may seek or need to provide quality care to Rhode Island's patients. Not all facilities and providers have the financial reserves or ability to meet the yearly requirements for risk-sharing contracts in the time frame and manner proposed. We respectfully request reconsideration of the proposed regulations' prescriptive targets to allow providers and payers more flexibility to develop the "right fit" for meeting Rhode Islands' health needs through system transformation. Rhode Island is unique, and its providers and payers are also unique in their approaches to care. A one-size-fits-all fixed target timeline leaves the potential for hindering the next innovative care idea the state's providers and payers may individually and collectively be seeking.

As one of the main supporters of the legislation that formed the Administrative Simplification Task Force, HARI and its members strongly support the continuation of its mission through the formation of the task force within OHIC under these proposed regulations. Over the past two years the task force has been a collaborative effort between OHIC, insurers and health care providers. The proposed regulations' streamlining of administrative processes relating to



retroactive terminations, coordination of benefits, timely filing appeals and proper management of medical records and requests all came from the most recent work of the task force as indicated in its March 2014 report to the General Assembly. As part of the task force, HARI supported these changes and we thank the Commissioner for her leadership in promulgating these recommendations into regulation.

HARI agrees that if health care payers and providers truly want to reduce health care expenses, we must all reduce the administrative burden the health care delivery system faces on a daily basis. Our members agree that four areas addressed in this proposed regulation are a significant first step in lowering the administrative costs of health care:

- Retroactive terminations - These can occur for many reasons but usually result in the re-processing of claims from payers, take-backs from providers, researching if there is a new payer or billing the patient, collections, etc. Eliminating this process will save significant time in all areas of the delivery system.
- Coordination of benefits (COB) – The standardization of the COB form and a central repository to identify primary insurance will also reduce administrative time to acquire payment for services rendered. It will also make completing the form simpler for the consumer and lessen the confusion among payers and providers regarding a patient’s coverage.
- Appeal of timely filing denials – This has been a very long process for providers in the past where in many cases the denials are a result of incorrect information being provided to the provider, not the fault of the provider. This will reduce this long process and ensure providers are reimbursed for services provided when processes are followed correctly.
- Medical records management – This regulation will ensure medical records are only requested as necessary. We want to ensure the privacy of all patients and not have payments delayed due to unnecessary requests or information not sent/received at the correct payer location.

We look forward to continuing to work with OHIC to transform health care, but need to ensure we are aligning initiatives, investing in our delivery system and not addressing expenses only through rate reductions. HARI encourages further discussion of the change in index for hospital increases and adoption of the administrative simplification regulations.

Thank you for your consideration of this matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Souza', with a long horizontal flourish extending to the right.

Michael R. Souza  
President