



Next Generation Affordability Standards: Concepts, Rationale, and Additional Information

Executive Summary

In early 2022, the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) intends to revise its Affordability Standards, outlined in [230-RICR-20-30-4.10](#), to continue to improve the affordability of health care in Rhode Island through the incorporation of next generation Affordability Standards. The Affordability Standards are a core component of the efforts of OHIC to meet its statutory purposes, including improving the health care system and protecting consumers by making health insurance more affordable. Currently, the Affordability Standards emphasize insurer investment in primary care, integration of physical and behavioral health care, utilization of alternative payment models, structural provider contracting requirements that limit cost growth and encourage quality improvement, and alignment of clinical quality measures across value-based contracts.

The next generation Affordability Standards currently in development represent an effort to broaden insurer accountability for improving affordability and health care system performance. As such, the new requirements under consideration include a behavioral health investment/spending requirement, a community investment requirement, and a professional services average annual price growth cap.

OHIC is exploring proposing a spending requirement for behavioral health care that will promote the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public. The qualifying behavioral health spending that would count toward the spending requirement would include both claims and non-claims payments that would be reported to OHIC on an annual basis. Behavioral health spending would be defined in a similar manner to the existing primary care spending requirement, including eligible provider types, sites of care, and procedure codes.

OHIC is exploring proposing a insurer community investment requirement that will mitigate growth in health care costs while advancing health equity, addressing social determinants of health (SDOH), and improving population health. The office is interested in considering several forms that such a requirement could take.

Finally, OHIC is exploring proposing the promulgation of a cap on average annual price growth for professional services (e.g., physician services or laboratory services). The office would apply a cap on the average annual price growth of professional services, similar to the regulations applied to hospital inpatient and outpatient services.

OHIC also specifically invites public comment regarding alternative regulatory approaches to these proposed requirements. It is OHIC's hope that this document will support the continuation of the vital dialogue the office has had to date with stakeholders around these next generation Affordability Standards.

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Introduction

In early 2022, OHIC intends to revise its Affordability Standards, outlined in [230-RICR-20-30-4.10](#), to continue to improve the affordability of health care in Rhode Island through the incorporation of next generation Affordability Standards. The purpose of this document is to inform stakeholders regarding the options under consideration by OHIC and to invite public comment in response to these options. From June 2021 through September 2021, OHIC initially reviewed and vetted these options in concept with a diverse array of stakeholders across 20 meetings.

Affordability Standards Background. The Affordability Standards are a core component of the efforts of OHIC to meet its statutory purposes including improving the health care system and protecting consumers by making health insurance more affordable. As part of the annual rate review process for commercial health insurance premiums, commercial health insurers are required to prove that the rates filed for approval by OHIC are consistent with the proper conduct of the insurer's business and the public interest. Given the public's interest in affordable health insurance, OHIC developed the Affordability Standards to systematize regulatory requirements that insurers must follow to demonstrate their efforts to improve affordability. Currently, the Affordability Standards emphasize insurer investment in primary care, integration of physical and behavioral health care, utilization of alternative payment models, structural provider contracting requirements that limit cost growth and encourage quality improvement, and alignment of clinical quality measures across value-based contracts.

Next Generation Affordability Standards Overview. The next generation Affordability Standards currently in development represent an effort to broaden insurer accountability for improving affordability by addressing three substantive areas:

1. Necessary investment in behavioral health services to ensure a well-functioning continuum of care for Rhode Islanders with behavioral health needs
2. Accountability for investment in initiatives to improve population health and address social determinants of health (SDOH)
3. Capping average annual price growth for select professional services

OHIC believes that, by addressing these substantive areas, significant opportunities exist to improve affordability while advancing broader health care system performance in the years ahead.

Behavioral Health Spending Requirement

Concept. OHIC is exploring proposing a spending requirement for behavioral health care that will promote the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public. Since 2011, OHIC has had a primary care spending requirement as part of the Affordability Standards, which requires insurers to dedicate at least 10.7% of annual medical spend to support and strengthen the capacity of primary care practices. In 2020, the Affordability Standards were further augmented to improve the integration of behavioral health care in the primary care setting by reducing patient cost-sharing and ensuring access to preventive behavioral health services.

The qualifying behavioral health spending that would count toward the spending requirement would include both claims and non-claims payments that would be reported to OHIC on an annual basis. Behavioral health spending would be defined in a similar manner to the existing primary care spending requirement, including eligible provider types, sites of care, and procedure codes. OHIC also specifically invites public comment regarding alternative regulatory approaches to the spending requirement for

behavioral health care that will promote the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public.

Rationale. Legislation was enacted in 2018 that augmented OHIC’s powers and duties under [State of Rhode Island General Laws \(RIGL\) § 42-14.5-3](#) with respect to the promotion of integrated behavioral health. These provisions direct OHIC:

- “To work to ensure the health insurance coverage of behavioral health care under the same terms and conditions as other health care, and to integrate behavioral health parity requirements into the office of the health insurance commissioner insurance oversight and health care transformation efforts”
- “To work with other state agencies to seek delivery system improvements that enhance access to a continuum of mental-health and substance-use disorder treatment in the state; and integrate that treatment with primary and other medical care to the fullest extent possible”
- “To direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery”

OHIC believes that promoting the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public is necessary to achieve its statutory charge and critical to prioritize.

The behavioral health care system in Rhode Island needs additional investment and support for transformation that will lead to improved health outcomes which support enhanced affordability. In fact, Rhode Island is among the bottom-performing states on some indicators of behavioral health system performance including the percentage of adults with any mental illness reporting unmet need,¹ alcohol-related deaths per 100,000 population,² and drug poisoning deaths per 100,000 population.³ Challenges with Rhode Island’s behavioral health system also surface in data related to overdose and suicide rates, emergency department utilization, substance use disorder rates, children’s behavioral health measures, and overall behavioral health system capacity constraints.

Additional Information. To inform the development of this requirement, the State of Rhode Island Executive Office of the Health and Human Services and OHIC are currently performing a behavioral health spending study that examines Rhode Island’s relative spending on behavioral health services, correlating that spending to outcomes, and benchmarking the data against other states. This analysis will help inform where behavioral health spending is most needed to lower costs, improve quality, and better address behavioral health needs of the public.

Community Investment Requirement

Concept. OHIC is exploring proposing a community investment requirement that will mitigate growth in health care costs while advancing health equity, addressing social determinants of health (SDOH), and improving population health. In this context, advancing health equity means “dismantling the systemic racism that underlies differences in the opportunity to be healthy, including addressing social and

1. “Adults with Any Mental Illness Reporting Unmet Need,” Health System Data Center, The Commonwealth Fund, accessed November 18, 2021, <https://datacenter.commonwealthfund.org/topics/adults-any-mental-illness-reporting-unmet-need>.

2. “Alcohol Deaths,” Health System Data Center, The Commonwealth Fund, accessed November 18, 2021, <https://datacenter.commonwealthfund.org/topics/alcohol-deaths>.

3. “Drug Poisoning Deaths,” Health System Data Center, The Commonwealth Fund, accessed November 18, 2021, <https://datacenter.commonwealthfund.org/topics/drug-poisoning-deaths>.

economic barriers to positive health outcomes [where] . . . progress toward the goal of health equity is often benchmarked by measuring reductions in health disparities.”⁴ OHIC is interested in considering several forms that such a requirement could take including but not limited to:

1. **Community Benefit Activities:** Insurers would be required to use a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct on an annual basis to fund community benefit activities that advance health equity, address SDOH, and improve population health. Excess surplus would be defined in a manner consistent with the notion that such a surplus level is one that would be able to withstand any probable drain from unexpected severity or incidence of claims. The defined amount of excess surplus would be utilized by the insurer to fund activities selected by the insurer and approved by OHIC in advance of providing the funding. Examples of the types of community benefit activities that would be consistent with the aims of this requirement could include addressing birth-related health disparities through support for programs that have demonstrated the ability to improve birth outcomes, the development of new housing units specifically designed for individuals and families who are homeless or at risk of becoming homeless, or the expansion and sustainability of community health teams. OHIC would notify the insurers annually on areas of suggested priority for community benefit activities informed by the solicitation of public input by OHIC.
2. **Community Investment Fund:** Insurers would be required to contribute a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct on an annual basis towards community initiatives that advance health equity, address SDOH, and improve population health. Excess surplus would be defined in a manner consistent with the notion that such a surplus level is one that would be able to withstand any probable drain from unexpected severity or incidence of claims. The defined amount of excess surplus would be contributed to a community investment fund to be established and administered by a philanthropic organization in partnership with OHIC. The community investment fund would support a focus upstream to address underlying inequities and influencers of health disparities such as affordable housing and food security. Eligible community initiatives to be supported by the community investment fund would be specified on an annual basis by the philanthropic organization in consultation with OHIC and informed by input from an advisory group of stakeholders, including consumers and employers representing communities that disproportionately experience poor health care outcomes as well as technical experts.
3. **Investment Portfolio Allocation:** Insurers would be required to allocate a portion of their investment portfolio that is consistent with both the public interest and proper business conduct to pooled investment vehicles that advance health equity, address SDOH, and improve population health. The allocation would take into account considerations such as “community, environmental and health benefits, as well as financial risks and returns, liquidity and geographic-related criteria.”⁵ OHIC would notify the insurers annually on areas of suggested priority for investment vehicles and approved by OHIC in advance of effectuating the allocation. This would be informed by the solicitation of public input by OHIC.

4. State Value & Health Strategies, *Talking about Anti-Racism and Health Equity: Discussing Racism* (Princeton, NJ: State Value & Health Strategies, August 2021), 4, <https://www.shvs.org/wp-content/uploads/2021/08/Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf>.

5. Community Catalyst, *Healthy Investments: Leveraging Health Plan Capital for Affordable Housing and Community Development* (Boston, MA: Community Catalyst, December 2019), 7, https://www.communitycatalyst.org/resources/publications/Healthy-Investments_final.pdf.

OHIC also specifically invites public comment regarding alternative regulatory approaches to community investment by insurers that would support the mitigation of health care cost growth as health equity is advanced, SDOH are addressed, and population health is improved.

Rationale. RIGL § 42-14.5-2 charges the health insurance commissioner with discharging the powers and duties of office to, among other purposes: “view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.” OHIC believes that developing a requirement that directs insurers to make investments in the community that are correlated with lower health care costs and improved health care quality to materially advance the welfare of the public is both consistent with its statutory charge and critical to prioritize.

Such a requirement is compelling, prudent, and rational given that the major insurers participating in the Rhode Island market:

- Have surplus levels that a preliminary review suggests is indicative of at least some financial ability to increase community investment
- Generate surplus from the profitability of their Medicare and/or Medicaid business (in addition to those generated from their commercial business), which are funded with public revenues and so some of these revenues are appropriately directed to community investment that advance the welfare of the public
- Are properly viewed as anchor institutions that are rooted in their local communities by mission, invested capital, and/or relationships to customers, employees, and vendors and which have the potential to bring crucial and measurable benefits to local children, families, and communities⁶

Additional Information. In order implement such a requirement in a manner consistent with another of OHIC’s statutory purposes outlined in RIGL § 42-14.5-2, to “guard the solvency of health insurers,” OHIC recognizes the need to conduct a comprehensive review of current insurer surplus levels to inform this effort (as well as other policymaking and regulatory enforcement). This comprehensive review would involve leveraging OHIC’s examination authority (RIGL § 27-13.1-3.1) to analyze current levels of surplus and determine whether those levels are efficient (i.e., not facing solvency issues from routine fluctuations), sufficient (i.e., able to withstand any probable drain from unexpected severity or incidence of claims) or inefficient (i.e., in excess of what is considered sufficient) as a result of applying the preceding conceptual framework for surplus efficiency for each insurer, considering current market conditions and the specific insurer characteristics.

Professional Services Average Annual Price Growth Cap

Concept. OHIC is exploring proposing the promulgation of a cap on average annual price growth for professional services (e.g., physician services or laboratory services). For over a decade, OHIC has capped average annual price growth for hospital inpatient and outpatient services through the regulation of insurer contracts. This regulatory construct has been effective at slowing health care cost growth in the Rhode Island market according to peer reviewed research published in the journal *Health Affairs*. Specifically, the researchers found that “relative to quarterly fee-for-service (FFS) spending among the control group, quarterly FFS spending among the Rhode Island group decreased by \$76 per enrollee after

6. Community Catalyst, *Healthy Investments*, 7.

implementation of the policy, or a decline of 8.1 percent from 2009 spending.”⁷ The authors concluded: “State regulators in Rhode Island achieved among the largest total health care spending changes observed from payment reforms to date.”⁸

Under this new requirement, OHIC would apply a cap on the average annual price growth of professional services, similar to the regulations applied to hospital inpatient and outpatient services. The cap would be linked to an economic index, such as the Consumer Price Index, or an alternative. It would be operationalized as a weighted average across the set of billable services offered by the provider where aggregate spending within each category of service (such as a specific evaluation and management codes) provides the weight.

OHIC is actively considering two refinements to this price growth cap construct for professional services that are different than the current price growth cap construct for hospitals. The first is that OHIC is considering excluding some provider specialties from the growth cap, such as behavioral health providers. In addition, or as an alternative, OHIC is actively considering excluding providers who are engaged in advanced value-based payment (VBP) from the price growth cap. Advanced VBP encompasses payment models, such as sub-capitation, that substitute prospective payment for fee-for-service payment. OHIC also specifically invites public comment regarding alternative regulatory approaches to the design elements of this proposal that will achieve the double aim of restraining price growth and incentivizing the efficient delivery of care through the transition to advanced VBP.

Rationale. RIGL § 42-14.5-2 charges the health insurance commissioner with discharging the powers and duties of office to, among other purposes: “view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.” OHIC believes that applying an average annual price growth cap to professional services is both consistent with its statutory charge and critical to prioritize.

Regulations that restrain cost growth are necessary to promote affordable health insurance and maintain a competitive insurance market, particularly in light of the variability in the relative size of insurers participating in the commercial market. Price growth is a key driver of cost growth.

Several data points and trends in the Rhode Island market point to need to address professional provider prices beyond the existing regulations on hospital prices. First, the effects of hospital acquisition of physician practices, otherwise known as vertical integration, on prices is relevant to recent Rhode Island market developments. Capps et al. (2018) examined the price effects of hospital acquisition of physician practices. The authors found that the prices for services offered by acquired physicians increased by 14.1%, on average, after the acquisition. The authors attribute 45% of the average price increase to the application of facility fees. Estimated price increases varied by physician specialty, with primary care prices estimated to increase by 15.1% and cardiology prices increasing by over 30%.⁹

Second, prior to consideration of the probable effect of increasing consolidation on provider prices, data from the [RAND 3.0 employer hospital price transparency study](#) showed that while Rhode Island has some of the lowest prices for hospital facility inpatient and outpatient services in the nation (relative to what Medicare would have paid for those services), the state has the sixth highest professional prices relative

7. Aaron Baum et al, “Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers,” *Health Affairs*, 38, no. 2 (February 2019): 237. <https://doi.org/10.1377/hlthaff.2018.05164>.

8. Aaron Baum et al, “Health Care Spending Slowed,” 244.

9. Cory Capps, David Dranove, and Christopher Ody, “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending.” *Journal of Health Economics*, 59 (April 2018): 139-153, <https://doi.org/10.1016/j.jhealeco.2018.04.001>.

to Medicare among the 46 states included in the study. It should be noted that the RAND study does not measure prices for all professional services, but only those that are functionally related to the provision of hospital inpatient and outpatient services, which was the focus of the RAND study. Still, for the professional services included in the RAND report, Rhode Island commercial payers reimbursed providers at a rate that was, on average, 256.1% of what Medicare would have paid.

Additional Information. To summarize, OHIC is soliciting public comment on a potential regulatory cap to be applied to the average growth of professional provider service prices. As stakeholders reflect and respond to this solicitation, they are encouraged to consider the following questions regarding the design features of a professional provider services growth cap.

1. Should the professional services price growth cap be effective only for provider prices that are above a defined Medicare relativity benchmark? For instance, if a provider's prices are above 150% of the Medicare rate, then the professional services rate cap would apply. If this design feature is desirable, how should the appropriate Medicare relativity benchmark be established?
2. Should certain providers be excluded from the professional services price cap? For example, providers types that do not constitute high-cost or high-cost growth service classifications.
3. Should providers that are engaged in advanced VBP for a significant portion of their revenue be excluded from the professional services price growth cap?
4. Are there other design features that OHIC should consider?
5. Are there any unintended consequences that should be considered?

Conclusion

It is OHIC's hope that this document will support the continuation of the vital dialogue the office has had to date with stakeholders around these next generation Affordability Standards. This will ultimately allow OHIC to improve the affordability of health care in Rhode Island through the incorporation of next generation Affordability Standards that benefit from a collaborative, expert, and transparent process. OHIC may also choose to revise existing Affordability Standards and encourages stakeholders to propose suggestions for consideration that are consistent with improved affordability, access, and quality.