RHODE ISLAND GOVERNMENT REGISTER

PUBLIC NOTICE OF PROPOSED RULEMAKING

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

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

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

Rulemaking Action: Proposed Amendment

Important Dates:

Date of Public Notice: October 11, 2024

Hearing Date: November 4, 2024

End of Public Comment: November 15, 2024

Rulemaking Authority:

R.I. Gen. Laws § 42-14.5-1 et seq.

42-14-5

and 42-14-17.

Summary of Rulemaking Action:

The Office of the Health Insurance Commissioner (OHIC) is proposing amendments to 230-RICR-20-30-4 Powers and Duties of the Office of the Health Insurance Commissioner. When creating OHIC, the General Assembly enumerated a list of statutory purposes 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:

1. Ensure effective regulatory oversight by the OHIC;
2. 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
3. Implement the intent of the General Assembly as expressed in the OHIC Purposes Statute.

This proposed rulemaking follows two recent OHIC reports. First, OHIC's December 2023 report: Primary Care in Rhode Island: Current Status and Policy Recommendations (https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-12/Primary Care in Rhode Island - Current Status and Policy Recommendations December 2023.pdf). This report presented findings from OHIC's state and national research on primary care trends, offered an assessment of the current state of primary care in Rhode Island informed by interviews with local stakeholders, and provided recommendations for future actions to support and strengthen primary care in the state. Second, OHIC's June 2024 Administrative Simplification Taskforce report: Prior Authorization – Final Report of Recommendations (https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-06/OHIC Administrative Simplification Task Force Report June 28 2024.pdf). This report was mandated by the General Assembly through legislation that amended OHIC's powers and duties in 2023. Each of these reports are the product of significant stakeholder engagement which informed substance of this rulemaking.

The proposed amendments lower the Affordability Standards accountability threshold for commercial health insurers from 10,000 covered lives to 5,000 covered lives, rebase and restructure OHIC's regulatory target for commercial health insurer primary care funding, address patient-centered medical home (PCMH) sustainability payments by decoupling them from total cost of care risk, and address health insurer prior authorization practices. The proposed amendments comprise technical modifications to § 4.3 Definitions, § 4.9 Affordable Health Insurance – General, § 4.10 Affordable Health Insurance – Affordability Standards, and § 4.11 Administrative Simplification. The regulation is further augmented by two new sections, § 4.13 Primary Care Specialty Provider Taxonomy Codes and § 4.14 Primary Care Payment Codes. The substance of the amendments and new sections of 230-RICR-20-30-4 are described in greater detail below. Collectively, the proposed amendments and retained provisions set forth regulatory standards for commercial health insurers to follow in their efforts to improve the affordability of their products and to promote accessible, high quality health care. OHIC developed these standards to meet its statutory mandate under R.I.G.L § 42-14.5-2, which states:

"With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:

1. Guard the solvency of health insurers;
2. Protect the interests of consumers;
3. Encourage fair treatment of health care providers;
4. Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
5. 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."

Primary Care Funding

The amendments addressing primary care funding are articulated in § 4.3, § 4.10(B), § 4.10(C), with related changes in other subsections of § 4.10, § 4.13, and § 4.14. The amendments embrace the following substantive areas:

1. OHIC is proposing to revise the definition of primary care expenditures to account for the development of consensus approaches to primary care expenditure measurement that have emerged in the 15 years since OHIC first established a primary care expenditure target. The studies that informed OHIC's selection of

measurement methodology are listed in Table 2, page 9, of the Regulatory & Cost-Benefit Analysis prepared for this rulemaking. In place of existing guidance on primary care provider types and categories of procedure codes that determine claims-based expenditure measurement, OHIC is proposing to adopt specific primary care specialty provider taxonomy codes (§ 4.13) and procedure codes (§ 4.14) within the body of the regulation. Adopting a code-based specification of claims-based primary care expenditures will ensure consistency across health insurers and facilitate auditing by OHIC.

2. In § 4.3 OHIC is proposing to discontinue the distinction between direct and indirect primary care expenses and adopt one definition of primary care expenditures that identifies allowable claims-based and non-claims-based expenditures. Non-claims-based payments shall be specifically attributed to the fully insured market. OHIC also proposes to add specific definitions of "primary care provider" and "total annual medical expenditures" in § 4.3. The definition of total annual medical expenditures aligns with existing definitions used to measure per capita health care spending and spending growth through OHIC's Health Spending Accountability and Transparency Program.
3. In § 4.10(B) the primary care expenditure target, which is defined as the ratio of primary care expenditures to total medical expenditures, is restructured to improve oversight of primary care expenditures by commercial health insurers and to incentivize increased financial support for primary care through service-based mechanisms, including reimbursement for primary care services delivered at an ambulatory primary care site of care and enhanced primary care capitation payments for attributed patients. OHIC is rebasing measured primary care expenditures and total medical expenditures to calendar year 2022 using the new methodologies and proposes to adopt an overall target for primary care expenditures as a percentage of total medical expenditures of 10% to be achieved over a multi-year period beginning in 2025. In addition to an overall target, the proposed amendments set forth a sub-target of 8% of total medical expenditures to be made through claims-based payments and/or primary care capitation payments.
4. OHIC proposes to modify the total medical expenditures denominator of the primary care expenditure target. This change will capture a greater percentage of the true total cost of care for fully insured Rhode Islanders by including payments to out-of-state providers. This is a material change from guidance and measurement under current regulation which is exclusively focused on payments to Rhode Island providers. This proposed change to the denominator better aligns with primary care's role managing total cost of care through risk-based contracts.
5. § 4.10(C) of the regulation is amended to explicitly require that care management and infrastructure payments to primary care practices designated by OHIC as PCMHs shall not be at risk for total cost of care performance but may be at risk for performance on quality measures. OHIC also proposes to require reporting of practice payments for each PCMH.
6. § 4.10(D)(2)(f) is amended to require that population-based total cost of care contract budgets shall be held harmless for mandated increases in primary care funding. In § 4.10(D)(2)(h) OHIC clarifies that health insurers and Integrated Systems of Care may negotiate contractual mechanisms to mitigate risk from high-cost specialty drugs.

The amendments to the primary care definition and expenditure requirement will improve OHIC's ability to hold insurers accountable for the appropriate financing of primary care that is necessary to ensure a high performing health care system and provision of affordable health insurance. The amendments will also improve OHIC's ability to ensure that primary care payments are directed to the timely support of primary care practices and clinicians.

Following promulgation of the final regulation, OHIC will publicly report primary care expenditure data by payer using the new definition, once finalized, and perform periodic market conduct examinations to audit compliance. Interested parties are encouraged to review the Regulatory and Cost-Benefit Analysis for more information on the proposed amendments.

Administrative Simplification – Prior Authorization

The proposed amendments to § 4.11 provide for a new set of standards governing prior authorization. The standards comprise six areas.

1. In § 4.11(F)(2) OHIC proposes to mandate a 20% reduction prior authorization volume compared to 2023 baseline volume on a normalized per member per month basis. Further, OHIC proposes to direct health insurers to volume reductions involving services, treatments, or procedures ordered by primary care providers.
2. In § 4.11(F)(3) OHIC proposes to require health insurers to develop and implement programs involving selective prior authorization requirements, based on stratification of health care providers' performance and adherence to evidence-based medicine with the input of contracted health care providers and/or provider organizations.
3. OHIC proposes to require health insurers to conduct a review of medical services, including behavioral health services, and prescription drugs, subject to prior authorization on at least an annual basis, with the input of contracted health care providers and/or provider organizations. Health insurers shall consider a number of factors, including administrative costs to providers, when deciding to add, maintain, or remove prior authorization requirements.
4. In § 4.11(F)(5) OHIC proposes to require quarterly reporting on prior authorization requests and other relevant data.
5. In § 4.11(F)(6) OHIC proposes to require submission of an annual attestation, including answers to a standard set of questions, regarding prior authorization processes and annual reviews of prior authorization requirements, in a form and manner determined by the Commissioner.
6. In § 4.11(F)(7) OHIC proposes to convene a statewide advisory committee on prior authorization that shall be a subcommittee of the Administrative Simplification Task Force. The advisory committee shall be comprised of representatives of health care providers and health insurers with relevant experience and expertise in prior authorization and other utilization management practices and processes. The advisory committee shall meet at least two times per year and will be charged with reviewing prior authorization data submitted to OHIC, health insurer attestations, and making recommendations to improve prior authorization processes for medical services and prescription drugs over time.

Non-technical modifications to grammar and form are proposed throughout the regulation.
The proposed amendments are supported by evidence and sound theory and are rationally related to the statutory purposes of OHIC.
A public hearing will be held remotely on Zoom on Monday, November 4, 2024, at 8am. You can join the hearing at this link: https://us06web.zoom.us/j/84503992297

Additional Information and Public Comments:

All interested parties are invited to request additional information or submit written or oral comments concerning the proposed amendment until November 15, 2024 by contacting the appropriate party at the address listed below:

Charles Estabrook

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Public Hearing:

A public hearing, in accordance with R.I. Gen. Laws § 42-35-2.5, to consider the proposed amendment shall be held at which time and place all persons interested therein will be heard. This hearing is subject to R.I. Gen. Laws Chapter 42-46, Open Meetings.

Public Hearing Information:

Date: November 4, 2024

Time: 8:00 A.M.

Location: Remote Hearing - Zoom
https://us06web.zoom.us/j/84503992297
https://ohic.ri.gov/
Cranston, RI, 02920

The place of the public hearing is accessible to individuals with disabilities. If communication assistance (readers/interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call 401-462-9658 or RI Relay 711 at least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting. For questions regarding available parking, please contact the agency staffperson listed above.

Regulatory Analysis Summary and Supporting Documentation:

Pursuant to the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.9 and Executive Order 15-07 OHIC conducted a regulatory and cost-benefit analysis of the proposed amendments. Interest parties are referred to the document Proposed Amendments to 230-RICR-20-30-4: Regulatory and Cost-Benefit Analysis for an assessment of the societal costs and benefits of the proposed amendments. OHIC believes the proposed amendments are likely to generate societal benefits which exceed the costs. The complete Regulatory and Cost-Benefit Analysis has been uploaded to SOS and can be found under the “Rulemaking Documents” tab on the RICR website link, and then click on "Studies/Reports."

For full regulatory analysis or supporting documentation contact the agency staffperson listed above.