

**State of Rhode Island and Providence Plantations
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
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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.*

(de) “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.

(ef) “Health insurer” means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service corporation, a non-profit medical service corporation, a non-profit dental service corporation, a non-profit optometric service corporation, a domestic insurance company subject to chapter 1 of title 27 of the General Laws that offers or provides health insurance coverage in the state and a foreign insurance company subject to chapter 2 of title 27 of the General Laws that offers or provides health insurance coverage in the state.

(gf) “Holding company system” has the same meaning as set out in R.I. Gen. Laws § 27-35-1 *et seq.*

(h) “Indirect Primary Care Expenses” means payments by the Health Insurance Issuer to support and strengthen the capacity of a primary care practice to function as a medical home, and to successfully manage risk-bearing contracts, but which do not qualify as direct primary care spending, in accordance with parameters and criteria issued in a bulletin issued by the Commissioner. Such payments shall include financial support, in an amount approved by the Commissioner, 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. By May 1, 2016 the Commissioner shall reassess this obligation by Health Insurers to provide financial support for the health information exchange.

(i) “Integrated System of Care”, sometimes referred to as an Accountable Care Organization, means a business entity consisting of physicians, other clinicians, hospitals and/or other providers that together provide care and share accountability for the cost and quality of care for a population of patients, and that enters into a shared savings contract or risk sharing contract with one or more Health Insurers to care for a defined group of patients.

(j) “Patient-Centered Medical Home” means: (i) a primary care practice recognized by the collaborative initiative endorsed by R.I.G.L. Chapter 42-14.6, or (ii) recognized by a national accreditation body, or (iii) an advanced primary care practice program established by contract between a Health Insurer and a primary care practice or an Integrated System of Care, and approved by the Commissioner. Such advanced primary care practice programs shall measure practice performance based upon pre-determined quality and efficiency criteria.

(k) “Population-Based Contract” means a provider reimbursement contract that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered-lives population. A population-based contract may be a Shared Savings Contract, or a Risk Sharing Contract. A primary care or specialty service capitation reimbursement contract shall not be considered a Population-Based Contract for purposes of this Section.

(l) “Primary Care Practice” means the practice of a 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, and contractually agrees to accept the responsibilities of a primary care provider.

(m) "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.

(n) "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.

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;¹
 - (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;

¹ 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.²

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

² 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;³ 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):~~

³ 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.~~
- ~~(I) — 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 1st 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, 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, 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.

(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 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 results.

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

(iv) An actuarial certification, prepared after examining the terms of the provider organization's risk sharing 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, global 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).

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 or 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 114 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 152 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: