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

(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 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 complying with 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.

(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.

Section 10. Affordable Health Insurance – Affordability Standards

(a) Health Insurers with at least 10,000 covered lives under a Health Insurance plan issued, delivered, or renewed in Rhode Island shall comply with the delivery system and payment reform strategy requirements set forth in this Section. For purposes of this Section only, a Health Insurer shall not include a non-profit dental service corporation, or a non-profit optometric service corporation.

(b) Primary care spend obligation. The purpose of this Subsection (b) is to ensure financial support for primary care providers in Rhode Island that will assist in achieving the goals of these Affordability Standards.

(1)(A) Each Health Insurer's annual, actual Primary Care Expenses, including both Direct and Indirect Primary Care Expenses, shall be at least an amount calculated as 10.7 percent of its annual medical expenses for all insured lines of business. Of the Health Insurer's annual Primary Care Expense financial obligation, at least 9.7 percent of the calculated amount shall be for Direct Primary Care Expenses. Each Health Insurer's Indirect Primary Care Expenses shall include at least its proportionate share for the administrative expenses of the medical home initiative endorsed by RIGL Chapter 42-14.6, and for its proportionate share of the expenses of the health information exchange established by RIGL Chapter 5-37.7e.

[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.

(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 after soliciting comments from stakeholders, and 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 statements. Indirect Primary Care Expenses shall be accounted for as administrative costs on the Health Insurer's annual financial statements. 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 28, 2015, by October 1, 2015, and by October 1 of each year thereafter. 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 Commissioner shall designate as members of the Committee individuals or organizations that can bring value to the work of the Committee representing: