REVISIONS TO 230-RICR-20-30-4

Powers & Duties of the Office of the Health Insurance Commissioner

Abstract

This paper has been prepared to facilitate the public's review of the proposed amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner, which includes the Affordability Standards

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Revisions to 230-RICR-20-30-4
Powers & Duties of the Office of the Health Insurance Commissioner

Executive Summary

The Office of the Health Insurance Commissioner (OHIC) is proposing amendments to 230-RICR-20-30-4 to advance critically important public interest objectives in the domains of behavioral health care for children and adolescents, health equity, and transparency into professional service provider prices. The proposed amendments follow the issuance of an Advance Notice of Proposed Rulemaking in 2021 through which OHIC solicited and considered thoughtful public comment submitted by interested parties on three policy constructs that comprised investment in behavioral health care, health insurer community benefit activities, and a professional services price growth cap. The proposed amendments described in this document reflect the input of interested parties and the further evolution of the agency's thinking on these subjects. This paper has been prepared to facilitate the public's review of the proposed amendments.

Introduction

OHIC is proposing amendments to 230-RICR-20-30-4 as described in the Notice of Proposed Rulemaking (NPR). The proposed amendments chiefly modify 230-RICR-20-30-4.10 by incorporating requirements to effectuate next generation Affordability Standards. The amendments aim to continue to improve the quality and affordability of health care in Rhode Island, which are among the public interest objectives that guide OHIC's work and are consistent with OHIC's statutory purpose outlined in State of Rhode Island General Laws (RIGL) § 42-14.5-2 which reads: "With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:

(1) Guard the solvency of health insurers;
(2) Protect the interests of consumers;
(3) Encourage fair treatment of health care providers;
(4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
(5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access."

To support the development of these amendments, in November 2021, OHIC issued an Advance Notice of Proposed Rulemaking (ANPR) that outlined three policy concepts the office intended to explore and to solicit stakeholder input on the three concepts.[1] The concepts addressed insurer investment in behavioral health services, community investment, and contracting guardrails to curb professional provider price inflation. The purpose of this document is to describe the concepts related to the proposed amendments that were explored in the ANPR, review the comments[2] received related to each concept, and provide

[1] See Next Generation Affordability Standards: Concepts, Rationale, and Additional Information

[2] OHIC received comments from the following parties: American Cancer Society Cancer Action Network, Blue Cross Blue Shield of Rhode Island, Care Transformation Collaborative of Rhode Island, Dr. John Concannon, Dr. Peter Hollmann, Dr. Mark Jacobs, Lifespan, MLPB, Neighborhood Health Plan of Rhode Island, Protect Our

OHIC's response to these comments to provide context for the proposed amendments put forward in the NPR. The next generation Affordability Standards to be effectuated through the proposed amendments are supported by evidence and sound theory and are rationally related to the statutory purposes of OHIC.

As a whole, the proposed amendments build upon OHIC's prior work to systematize regulatory requirements that insurers must follow to demonstrate their efforts to improve affordability and quality. Currently, the Affordability Standards emphasize insurer investment in primary care, integration of physical and behavioral health care, utilization of alternative payment models, structural provider contracting requirements that limit cost growth and encourage quality improvement, and alignment of clinical quality measures across value-based contracts. OHIC believes that, by addressing the substantive areas of behavioral health care investment, health equity, and transparency with the next generation Affordability Standards put forward through the proposed amendments, significant opportunities exist to improve affordability while advancing broader health care system performance in the years ahead. In addition to the three new policy concepts described in the NPR, OHIC is proposing amendments to other subsections of Regulation 4 and those amendments are described below.

Behavioral Health Spending Requirement

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

The concept articulated in the ANPR employed the existing primary care spending requirement as an analog. Accordingly, qualifying behavioral health spending that would count toward the spending requirement would include both claims and non-claims payments that would be reported to OHIC on an annual basis. Behavioral health spending would be defined in a similar manner to the existing primary care spending requirement, including eligible provider types, sites of care, and procedure codes, but would require a behavioral health diagnosis on the claim. OHIC also specifically invited public comment regarding alternative regulatory approaches to the spending requirement for behavioral health care that will promote the development of a high-quality, well-functioning delivery system capable of serving the comprehensive physical and behavioral health care needs of the public.

Review of Comments. The behavioral health care spending concept articulated in the ANPR garnered thoughtful feedback from an array of interested parties. Commentors generally agreed that Rhode Island's behavioral health care delivery system faces challenges and that the collective efforts of providers, payers, and policymakers is necessary to strengthen Rhode Island's behavioral health care delivery system.

Consumer advocacy groups and service providers offered their perspectives on the root causes of the challenges facing Rhode Island's behavioral health care system. The Rhode Island Parent Information

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Healthcare Coalition RI, Rhode Island Health Center Association, Rhode Island Parent Information Network, The State of Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals, The State of Rhode Island Executive Office of Health and Human Services, The Substance Use and Mental Health Leadership Council of RI, Point32Health, and UnitedHealthcare.

Network (RIPIN) observed that "gaps in services faced by Rhode Islanders with behavioral health needs largely, if not entirely, stem from underinvestment. This underinvestment contributes directly to the lack of sufficient provider workforce capacity, the unavailability of many intermediate and community-based alternatives to hospitalization, and the fact that more than half of Rhode Islanders receiving residential substance use disorder treatment receive that treatment outside of RI, MA, or CT." Protect Our Healthcare Coalition RI cited statistics from the State of Mental Health in America report issued by Mental Health America, including the finding that "25.4% of Rhode Island adults with a mental illness reported that they were not able to receive the treatment they needed" and "64.9% of Rhode Island youth with major depression do not receive any mental health treatment." The Coalition echoed RIPIN's diagnosis of systemic underinvestment. Citing a recent survey by the Mental Health Association of Rhode Island, the Coalition identified the correction of "low reimbursement rates paid for behavioral health services as necessary to fix existing network inadequacies, including but not limited to child psychiatry, intermediate level behavioral health hospitalization, early intervention services, and substance use disorder services."

Lifespan and the Rhode Island Health Center Association (RIHCA) also expressed support for increased investment in behavioral health care.

Protect Our Healthcare Coalition RI, RIPIN, and RIHCA commented further, that in addition to any future behavioral health care investment requirements promulgated under the Affordability Standards, health insurers bear an existing legal obligation to behavioral health care parity. On this theme RIPIN wrote: "OHIC retains the authority to enforce these existing parity laws independently from and in addition to any new requirement regarding total spend, and we recommend that any regulatory language emphasize that distinction."

State agency partners, the Executive Office of Health and Human Services (EOHHS) and the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals, also provided comments on the proposal. EOHHS has been a leader investing in analysis, policy development, and strategic thinking on the present and ideal future state of Rhode Island's behavioral health care system. The Rhode Island Behavioral Health System Review Final Report published in July 2021 offers a view into the behavioral health care system that is of immense value to the public and policymakers. The report described the present state of Rhode Island's behavioral health care system by examining a set of *core indicators*. Specifically, EOHHS found the "core indicators – including overdose death rate and substance use rates – indicate significant concerns with Rhode Island's behavioral health system. Challenges with Rhode Island's behavioral health system surface in data related to suicide rate, homelessness rate, emergency department utilization, treatment volume in correctional settings, employment rate of behavioral health clients, and children's behavioral health measures."

Additionally, the report found:

1. "Rhode Island has several behavioral health system capacity challenges to address including both gaps in key service lines and a shortage of linguistically and culturally competent providers, that together disproportionately negatively impact communities of color.
2. Underlying drivers that perpetuate the challenges described above include:
    i. Fragmentation in accountability both across state agencies and across providers, insufficient linkages between services to support care coordination and transitions of care, and a lack of integration between behavioral health and medical care.
    ii. Payments for behavioral health services largely rely on a fee-for-service chassis that does not account for quality or outcomes.

iii. Lack of sufficiently modern infrastructure hinders providers of behavioral health services in Rhode Island, as well as creates barriers for Rhode Island to monitor the behavioral health system effectively and efficiently on an ongoing basis."

Commenters offered a range of suggested areas for future investment in behavioral health care. RIPIN stated:

> Areas of particular concern in Rhode Island's behavioral health system infrastructure should be given particular attention within the regulatory structure OHIC anticipates constructing to implement such a behavioral health spending requirement. Investment should be directed to areas where gaps and significant shortages have been identified, including home-based therapeutic services (HBTS) and applied behavioral analysis (ABA) services for children; community step down services for children and adults; residential treatment facilities; transition age youth services; preventive services; intermediate inpatient and intensive outpatient services; and mobile crisis treatment services.

The Care Transformation Collaborative of Rhode Island (CTC-RI) shared insights from its primary care practice transformation work. CTC-RI stated that "[p]rimary care in Rhode Island has been able to achieve significant success by taking a multi-payer stakeholder approach including developing a patient centered medical home common contract, metrics, payments and accountability framework."

Several health insurers offered comments on the proposal. Tufts Health Plan stated: "While we do not oppose a minimum spend requirement for BH, increased investment in BH must be balanced by decreased spending from other parts of the health care system, so that total health care spending is not increased. Tufts Health Plan cautioned that "[r]equired spending levels constrains our ability to manage overall costs and, ultimately, offer the most affordable premiums possible to our employer clients and consumers. A required spending level for behavioral health services, coupled with existing spending requirements for primary care, Care Transformation Collaborative programs, and a hospital rate cap – which is often viewed as a defined increase, rather than a maximum increase – severely constrains a health plan's ability to manage overall costs and demonstrate innovation within its provider health system arrangements."

UnitedHealthcare argued a "continued focus on primary care has the best potential to achieve OHIC's desired result and that the adoption of a similar spending requirement for other specialties could be dilutive to the impact and learnings we hope to achieve from the primary care program."

Neighborhood Health Plan of Rhode Island (NHPRI) commented: "Neighborhood supports OHICs goal of ensuring appropriate resource investment from commercial insurers in the behavioral health system, so long as these resources are focused on several key areas. These areas include increasing primary care integration, targeted workforce investment, and developing services to fill in gaps in Rhode Island's behavioral health continuum. Neighborhood believes addressing these areas is best achieved through targeted means as opposed to broad resource distribution."

Blue Cross Blue Shield of Rhode Island (BCBSRI) noted "Rhode Island faces many challenges in advancing behavioral healthcare and the integration of behavioral healthcare into primary care. These include lack of electronic medical records, lack of timely notification of discharge from emergency departments or inpatient settings, and general coordination of care issues." As an alternative to a spending target, BCBSRI recommended that "OHIC should consider mechanisms that would address these challenges. Doing so will improve the continuum of care, increase access, and improve integration and quality. Toward that end, we [BCBSRI] encourage building on the foundational, collaborative, all-payer, all-provider care transformation-type work, in conjunction with the Executive Office of Health & Human Services to define what should be invested in and create a road map, prior to imposing a regulatory obligation on spending."

OHIC Response. OHIC is grateful to those who submitted feedback on the proposal. In 2018, the powers and duties of OHIC that are enumerated in RI Gen. Laws § 42-14.5-3 were augmented to incorporate a specific focus on behavioral health. Specifically, the statute empowers OHIC to "direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral healthcare delivery." Following the amendments to OHIC's powers and duties, in 2020 OHIC promulgated amendments to the Affordability Standards that addressed plan design barriers to access to co-located physical and behavioral health services. In the proposed amendments OHIC is turning its focus to ensuring that strategic investments are made in Rhode Island's behavioral health care system to "address the behavioral health needs of the public."

In consideration of public input and further reflection and study on the ANPR proposal, OHIC has chosen to pursue a more refined approach to directing strategic investments in behavioral health care as an initial step in building toward a more holistic approach in the future. The analog to the primary care spending requirement is not a perfect one. Behavioral health care comprises a more heterogeneous set of services, settings of care, and provider types than primary care. Given this heterogeneity, the minimum primary care expenditure construct may not be generalizable to behavioral health care without significant effort to prioritize population needs and disciplines within behavioral health care service delivery where there are empirically verified gaps in capacity. OHIC believes that a more iterative approach is necessary, given constraints on present resources, and the need to create multi-payer alignment to meaningfully address gaps in the delivery system. Since the ANPR was issued in 2021, two developments have occurred that were pivotal in shaping OHIC's thinking on where priority should be placed during the initial stages of this policy development. First, in April 2022 the Rhode Island Chapter of the American Academy of Pediatrics, Rhode Island Council for Child and Adolescent Psychiatry, Hasbro Children's Hospital, and Bradley Hospital jointly issued a Declaration of a Rhode Island State of Emergency in Child and Adolescent Mental Health. Second, a recent report by Rhode Island KIDS COUNT, Children's Mental Health in Rhode Island, highlighted the significant burden of mental health issues facing children and adolescents in the state. Together these documents motivated OHIC to prioritize strategic investment in behavioral health care for children and adolescents. OHIC's rationale and the proposed approach are described in the Overview of Proposed Amendments below.

OHIC agrees with RIPIN, RIHCA, and the Protect Our Healthcare Coalition that health insurers bear a legal obligation to behavioral health care parity. OHIC will enforce insurer parity obligations and disagrees that language proposed by RIPIN to emphasize the distinction between parity obligations and other policies focused on strategic investments through the Affordability Standards is necessary.

Finally, OHIC will work collaboratively with other executive branch agencies, the general assembly, and non-governmental interested parties to address the challenges facing the state's behavioral health care providers and serve the needs of the state's residents.

Community Investment Requirement

ANPR Proposal Explored. In the ANPR, OHIC explored proposing a community investment requirement that will mitigate growth in health care costs while advancing health equity, addressing social determinants of health (SDOH), and improving population health. In this context, advancing health equity means "dismantling the systemic racism that underlies differences in the opportunity to be healthy, including addressing social and economic barriers to positive health outcomes [where] . . . progress

toward the goal of health equity is often benchmarked by measuring reductions in health disparities."[3] OHIC put forward several forms that such a requirement could take including but not limited to:

1. **Community Benefit Activities:** Insurers would be required to use a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct on an annual basis to fund community benefit activities that advance health equity, address SDOH, and improve population health. The defined amount of excess surplus would be utilized by the insurer to fund activities selected by the insurer and approved by OHIC in advance of providing the funding.
2. **Community Investment Fund:** Insurers would be required to contribute a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct on an annual basis towards community initiatives that advance health equity, address SDOH, and improve population health. The defined amount of excess surplus would be contributed to a community investment fund to be established and administered by a philanthropic organization in partnership with OHIC.
3. **Investment Portfolio Allocation:** Insurers would be required to allocate a portion of their investment portfolio that is consistent with both the public interest and proper business conduct to pooled investment vehicles that advance health equity, address SDOH, and improve population health. OHIC would notify the insurers annually on areas of suggested priority for investment vehicles and approved by OHIC in advance of effectuating the allocation. This would be informed by the solicitation of public input by OHIC.

Review of Comments. The community investment proposal prompted thoughtful feedback from several interested parties. The health insurers, whose reserves and investment decisions are the subject of the proposal, offered substantive feedback.

NHPRI urged OHIC to "consider the use of [a] maximum reserve threshold as an alternative measure to address this goal. The floor set for adequate reserve levels is important relative to protecting the financial health of insurers, but the community investment goal may be aided by considering an upper reserve threshold that would trigger the need for an appropriate level of mandated community investment. This would seek to ensure that insurers making windfall profits are contributing some amount of those funds back into the community as opposed to all insurers regardless of reserve status." NHPRI continued: "Neighborhood generally believes that any allocation of these resources should take account existing appropriate community investment levels and should consider ongoing and new investments within a broad set of flexible guidelines that leave considerable autonomy in the hands of the health plan. There is little consensus on a single type of investment in SDOH that has proven more successful, and these needs are likely to vary by community."

BCBSRI articulated its support of "the goals of advancing health equity, addressing social determinants of health (SDOH), and improving population health." BCBSRI described some of its recent initiatives as follows:

> "BCSBRI funded and produced the Rhode Island Life Index in collaboration with the Brown University School of Public Health. The Rhode Island Life Index is a statewide perception survey about the barriers, e.g., social determinants, to Rhode Islander's health and just completed its third year. From the results of this survey, we have directed our philanthropy to the areas which were found to be the biggest barriers to health, most notably access to safe affordable housing. Since 2020, we have focused our competitive BlueAngel Community Health Grants program on

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

investments in programs where housing and health intersect. We have awarded over $1.5 Million under this program to 18 agencies since 2020. In addition, we have awarded over $600,000 to funding an aging in place program with Greater Providence Habitat for Humanity."

On the specific proposal described in the ANPR, BCBSRI stated: "Notwithstanding our commitment to advancing health equity and addressing SDOH, we believe any requirement on insurers to make such investments is beyond OHIC's authority. Instead, we urge OHIC to consider adopting requirements that would advance the standardized collection and utilization of self-reported race, ethnicity, language (REL), and sexual orientation and gender identity (SOGI) data to measure health system performance and progress. For example, OHIC might require insurers to:

- Implement REL and SOGI data collection mechanisms and tie provider incentives to provider collection of and reporting of certain quality metrics by REL.
- Use advanced analytic models to segment "at risk" and "cost bloomers" to close disparities and gaps in care.
- Build REL metrics into VBC models to identify issues related to SDOH such as maternity bundles aimed at reducing infant mortality.

We recommend that OHIC, based on input from insurers and providers, adopt a standard definition for REL data collection such as the HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status."

Tufts Health Plan opposed the proposal as well, stating "[t]he appropriate means for carriers to make community investments is not through reserves, but rather through their charitable foundations. Reserves are meant to ensure carriers have adequate resources to cover future claims costs, particularly in the event of a pandemic like COVID-19. Additionally, assessments on carrier reserves will cause undue premium increases for our employer clients and run counter to the affordability principles OHIC has put forward." UnitedHealthcare argued "the proposed funding approach focusing on "excess surplus" adopts a methodology and accounting principle associated with a particular type of health insurer and attempts to apply the concepts of surplus to insurers who must follow other accounting and tax requirements. In addition, the proposed "excess surplus" based approach does not appear to focus the comparative amount of the assessment on current Rhode Island commercial business but instead looks at accumulated surplus from prior periods and other lines of business. Aside from any legal concerns, this approach could result in the situation where an insurer with dominant market share in the Rhode Island commercial market actually having lower assessment than a competitor with significantly less market share. In such case, the proposal would negatively impact competition and be counter to the affordability goals of the proposal."

RIHCA wrote in support of "the concept of investments to address the social determinants of health and equitable health care system. Should OHIC pursue insurance surplus spending, decisions should include public input, allow flexibility in insurer investments, and align closely with existing initiatives. Additionally, surplus spending should not jeopardize the stability of reserves to ensure funds remain to protect consumers." The Protect Our Healthcare Coalition wrote in support of the construct included in the ANPR and suggested that the creation of a community investment fund would be preferable. The Coalition wrote, "If social determinants are adequately addressed, we have the potential to reduce down-stream healthcare spending while also improving the overall quality of life for Rhode Islanders. Community benefit program investments can be tied to already defined public health measures as outlined by the RI Department of Health, and could target disparities in access to safe housing and healthy food; reducing exposure to environmental toxins; creating culturally appropriate and accessible public health

programming; and so much more." The Rhode Island Parent Information Network also wrote in support of the proposed policy construct, though it did not state a preference for any of the specific models described in the ANPR.

OHIC Response. OHIC appreciates the feedback offered by interested parties on the community investment policy construct articulated in the ANPR. Since the ANPR was issued in November 2021, OHIC has explored options to conduct a formal analytic assessment of insurer reserves/surplus to inform appropriate capital and surplus operating ranges. Such an analysis would assess the appropriateness of an upper bound to allowable surplus, given the laws governing health insurer risk-based capital and the public interest. Until such an analysis has been produced, OHIC will defer further consideration of health insurer community investment requirements.

OHIC recognizes that there are important actions that health insurers can undertake to address the needs of the community, particularly in the sphere of health equity. BCBSRI urged "OHIC to consider adopting requirements that would advance the standardized collection and utilization of self-reported race, ethnicity, language (REL), and sexual orientation and gender identity (SOGI) data to measure health system performance and progress." OHIC agrees that rules to advance the standardized collection and utilization of self-reported data on race, ethnicity, and other characteristics is foundational to measuring and addressing health disparities. In the Overview of Proposed Amendments below we describe a proposal to add a new Health Equity subsection to section 4.10 of Regulation 4.

Professional Services Average Annual Price Growth Cap

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

OHIC would consider excluding some provider specialties from the growth cap, such as behavioral health providers. In addition, or as an alternative, OHIC would consider excluding providers who are engaged in advanced value-based payment (VBP) from the price growth cap.

Review of Comments. OHIC received feedback on the proposal from several interested parties. Some commentors warned of potentially deleterious effects on the Rhode Island market's ability to recruit and retain talent in specialties where reimbursement increases would be subject to a growth cap. Other commentors were supportive of the policy construct, while others withheld a position until the full details of a proposal were specified.

In response to the proposal, Lifespan noted "the potential in a small state like RI for the unintended consequence of a flight of talent to neighboring states resulting in a scarcity or absence of certain subspecialty services if caps become a barrier to offering competitive reimbursement to such providers." Dr. Peter Hollmann expressed a similar concern, stating "[a]s a small state there are challenges in any cap that could simply lead professionals to locate cross border and get uncapped fees whereas those that stay in the communities they serve suffer." The dynamic of regional movement of providers described by Dr. Hollmann calls to mind a comment offered by Dr. Mark Jacobs, retired primary care provider and current member of the OHIC Health Insurance Advisory Council. Dr. Jacobs wrote:

> "Large hospital systems in the greater Boston area are implementing aggressive business plans to grow their primary care referral base to increase profitability and market share. Using their access

> to capital, these systems either purchase primary care practices (at multiples of their value) or enticed them (via lucrative bonuses and fee schedules) into tightly managed networks whose main purpose is to feed highly profitable ancillary services, employed specialists, and profit generating inpatient and outpatient service lines. "Leakage" of patients for services out of network to lower cost (but equal quality) providers or hospitals is strongly discouraged."

In reference to the existing price growth cap applied to hospital contracts, the Protect our Healthcare Coalition stated that "Rhode Island has been a leader nationally in demonstrating the effectiveness of price growth caps in healthcare through our existing affordability standards." The Coalition expressed support for the extension of the construct to professional services with the caveat that certain types of provider types, including professional behavioral health providers, be excluded from the cap. Similarly, the Rhode Island Parent Information Network wrote in support of the construct but emphasized the importance of certain features that would target the cap to the specialties of greatest concern. "[S]uch a price growth cap should be waived for specialties and subspecialties where capacity is limited, including behavioral health and pediatric specialists," RIPIN wrote. Further, RIPIN recommended "the price growth cap be benchmarked, where it would apply variably to providers depending on how far above that benchmark their prices currently lie – such a model could assist with (or obviate the need for) identifying specialties where capacity issues exist due to low rates."

Health insurers also provided comments on the proposal. UnitedHealthcare argued: "The proposed cap on professional services may result in unintended cost growth by creating an artificial base increase for all providers. The increase offers a one size fits all solution which hinders health plans' and providers' ability to negotiate contracted rates based on performance and need. Further, it will be challenging to find the right benchmark and method for determining the year over year increase methodology." In a similar vein, Tufts Health Plan commented "providers and health systems often view the growth caps as a minimum increase to reimbursement. Moreover, the volatility of growth caps being applied to the benchmark of Consumer Price Index (CPI) and the exacerbation of such trend being compounded by the additional OHIC increase (i.e., CPI + 1%), results in I) variation in forecasting and pricing for the plan and its fully-insured clients and II) elimination of predictability of medical expense for our self-insured clients."

BCBSRI expressed support for a professional services price growth cap. In response to the specific questions regarding potential design features of a professional services price growth cap, BCBSRI proposed that the "price growth cap should apply to all professional services regardless of Medicare relativity. We [BCBSRI] recommend that there be an inflationary cap on high-cost professional services (as measured by PMPM targeting the top 20 service categories), consistent with the cost trend work. Consideration should also be given to any service categories beyond the top 20 for which there is limited competition in Rhode Island." Overtime, price growth caps could be expanded to other services.

BCBSRI also recommended that OHIC consider a proposal to cap commercial sector prices and price growth authored by Michael E. Chernew, Leemore S. Dafny, and Maximilian J. Pany.[4]

OHIC Response. Since the ANPR was issued in November 2021 significant changes in the regional and national economic contexts have occurred. Inflation, which was running at a higher 12-month rate in November 2021, has accelerated to levels not seen in forty years. Against the backdrop of inflation, local health care providers have reported difficulty with workforce recruitment and retention. In light of these

[4] Michael Chernew, Leemore Dafny, and Maximilian Pany, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market* (The Hamilton Project, 2020). https://www.brookings.edu/research/a-proposal-to-cap-provider-prices-and-price-growth-in-the-commercial-health-care-market/

challenges, OHIC has decided to defer consideration of a professional services price growth cap. OHIC will evaluate cost driver analyses being produced under the auspices of the Health Spending Accountability and Transparency Program and conduct targeted surveillance of price growth through the annual rate review process prior to promulgating any specific caps on professional prices.

In the Overview of the Proposed Amendments, below, we describe a new contract provision to be integrated into professional provider contracts to facilitate market oversight and substantiate health insurer-filed unit cost trend assumptions during the annual premium rate review process. As regulators focused on improving affordability, it is essential that we have insight into the terms of contract, and business practices, that influence the total cost of heath care, which is the key driver of premiums.

Overview of the Proposed Amendments

Investment in Children's Behavioral Health. OHIC considered adopting a requirement that commercial health insurers increase their expenditures on behavioral health care in total, measured as a percentage of total spending. This policy construct was described in Next Generation Affordability Standards: Concepts, Rationale, and Additional Information which was released with the Advance Notice of Proposed Rulemaking in November 2021. The proposal was informed by OHIC's experience with a primary care spending requirement for health insurers participating in the commercial market. From 2010 through 2014, commercial health insurers were required to increase their expenditures on primary care, as a percentage of total spending, by one percentage point per year. This resulted in an approximate doubling of primary care's share of total medical spending by the end of the five-year period. The increased funding supported care management within primary care practices, funded pay-for-performance initiatives, and behavioral health care integration into primary care, among other initiatives. Currently, OHIC regulations require health insurers to dedicate at least 10.7% of total medical spending to primary care.

Behavioral health care is a more heterogeneous class of services and incorporates a more diverse set of provider types and settings of care than primary care. This creates challenges when formulating a policy that seeks to improve health care outcomes by increasing expenditures as a form of investment in provider capacity and population-focused programs. The heterogeneity of services and provider types within behavioral health care risks spreading the capacity investment too thin and undermining the benefits of coordination of investments across insurers. For this reason, OHIC has chosen to adopt an approach to behavioral health care spending by initially focusing on children and adolescents. The proposal entails measuring behavioral health care spending in total and measuring spending stratified by setting of care and age bands that have policy significance.

Pursuant to the proposed amendments, health insurers will be required to report annual expenditures on behavioral health care services for their fully insured population in a form and manner determined by the health insurance commissioner. The commissioner shall issue guidance on the definition of behavioral health care. The guidance shall include an approach for stratifying the data by setting of care and age. Further, the commissioner will publish reports on insurer behavioral health care expenditures in total and with a specific focus on children and adolescents. By January 1, 2024 each health insurer shall increase baseline per member per month (PMPM) expenditures on community-based behavioral health care for children and adolescents by 200%. Behavioral health care comprises mental health care and substance use treatment and is diagnosis based.[5]

[5] Services should be identified as behavioral health if the primary diagnosis is one of the following ICD-10 codes: between F01 and F69, F90 and F99, X710 and X838, T36000 and T71232 but diagnosis has a 2 in last

There is a strong rationale for placing priority on strategic investments for the care of children and adolescents. It is well documented that the COVID-19 pandemic has had significant impacts on children and adolescents. A recent report by Rhode Island KIDS COUNT, Children's Mental Health in Rhode Island, highlights the burden of mental health issues facing children and adolescents in the state. Rhode Island children and adolescents also face substance use issues. In April 2022 the Rhode Island Chapter of the American Academy of Pediatrics, Rhode Island Council for Child and Adolescent Psychiatry, Hasbro Children's Hospital, and Bradley Hospital jointly issued a Declaration of a Rhode Island State of Emergency in Child and Adolescent Mental Health.

Rhode Island KIDS COUNT summarized the outcome of mental health in children and adolescents as follows:

> "Mental health in childhood and adolescence is defined as reaching expected developmental, cognitive, social, and emotional milestones and the ability to use effective coping skills. Mental health influences children's physical health as well as their behavior at home, in school, and in the community. Mental health conditions can impair daily functioning, prevent or affect academic achievement, increase involvement with the juvenile justice and child welfare systems, result in high treatment costs, diminish family incomes, and increase the risk for suicide."[6]

Regulatory action to require increased expenditures on community-based behavioral health care programs and services for children and adolescents will create a pool of funds available for evidence-based interventions. To the extent that these interventions improve mental health outcomes and mitigate substance use issues among children and adolescents, society can garner significant benefits in the form of improved educational outcomes by students, improved earning capacity in adulthood, reduced interaction with the juvenile justice and child welfare systems, and potentially reduced suicide ideation and completion.

OHIC will garner lessons from the analysis and reporting of total behavioral health care spending, and the implementation of a specific requirement to increase expenditures on community-based services for children and adolescents, to inform the development of future policies to drive strategic investment in other areas of behavioral health care. Concurrent with these initiatives under the Affordability Standards, OHIC will continue to enforce behavioral health parity laws.

Health Equity Requirements. The proposed amendments create a new Health Equity subsection within § 4.10 that articulates a set of actions that health insurers should undertake to establish foundational processes for measuring health disparities in order to close those disparities within their covered populations. This requires that health insurers obtain National Committee for Quality Assurance (NCQA) Health Equity Accreditation or NCQA Health Equity Accreditation Plus by July 1, 2024. Health insurers will be required to follow demographic data collection principles and demographic data use principles governing the collection and use of self-reported demographic data, which is defined in the proposed amendments to mean "self-reported data on race, ethnicity, preferred language, sex assigned at birth, gender identity, sexual orientation, and disability."

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position, 2900 and 3149, E9550 and E9559, E9580 and E9589 or Diagnosis = E9518, E9520, E9528, E9529, E9500, E9511, E9530, E9531, E9538, E9539, E954, E956, E9570, E9571, E9572, E9579, E959, V6284. For prescription drug-based spending, OHIC will publish a list of drugs commonly used in the treatment of mental health and substance use disorders.

[6] Rhode Island KIDS COUNT, *Children's Mental Health in Rhode Island* (Providence, RI: Rhode Island KIDS COUNT, October 2022), 1, https://www.rikidscount.org/Portals/0/Uploads/Documents/10.24.22%20Mental%20Health%20Brief.pdf?ver=2022-10-24-165353-710

OHIC will convene a working group by October 2023 to develop recommendations, for consideration by the Commissioner, on specific demographic data collection standards and demographic data use standards. By October 2024, OHIC will convene a working group to develop recommendations, for consideration by the Commissioner, on specific requirements for health insurers to tie provider financial incentives to meaningful progress in remediating health disparities identified by the collection and use of demographic data. The proposed amendments would require insurers to obtain demographic data for at least 80% of members by January 1, 2025 and tie provider financial incentives to meaningful progress in remediating health disparities identified by the collection and use of demographic data by January 1, 2026.

The proposed amendments are informed by OHIC participation on the National Association of Insurance Commissioners (NAIC) Special (EX) Committee on Race and Insurance. Further, the OHIC Quality Measure Alignment and Review Committee has integrated equity analysis into its annual measure review and selection process. Building on the clear public interest in the identification and remediation of avoidable disparities in health care outcomes and processes, standardized data collection and the specification of provider financial incentives to address health equity are logical extensions of OHIC policies.

Professional Provider Contract Terms. The marginal contribution of annual price increases to total health care expenditures is borne by working Rhode Islanders and employers in the form of higher premiums and out of pocket expenses. As an agency with prior approval rate review authority and a longstanding mission to improve affordability, quality, and access, it is critically important that OHIC be able to systematically collect information on the structure of the system of prices that commercial health insurers pay to professional providers. The information will promote an improved understanding of the impact of price changes on total health care spending and premiums, an understanding of market dynamics that result in some provider specialties being paid prices that far exceed other specialties and will facilitate OHIC's efforts to substantiate unit cost trend data filed as part of the annual rate review process.

The proposed amendments create a new subsection in § 4.10(D) governing the terms of professional provider contracts. Professional providers are those that bill using electronic claim form 837P and/or form CMS-1500. The new subsection will require that health insurers include "terms that relinquish the right of either party to contest the release of the contract, or parts thereof, to the office of the health insurance commissioner; 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." This proposed requirement is modeled on an existing requirement for hospital contracts that can be found in § 4.10(D)6.

The specific terms of contract are important for understanding how prices and price changes impact the total cost of care and health insurance premiums. OHIC has access to the Rhode Island all-payer claims database, but there are limitations to our ability to discern true price increases that are the result of contract negotiations as opposed to changes in "price per unit of service" which is measurable from claims data but does not control for the mix or intensity of the units of services that enter the "price per unit" calculation.

Changes to Existing Provisions of Regulation 4. In addition to the three new substantive additions to Regulation 4 described above, OHIC has proposed the following amendments to existing provisions of the regulation.

§ 4.10(D)(2) – Population-based contracts. This section was amended to align language that describes the annual population-based contract budget growth cap with language on the newly proposed standard method of identifying the Consumer Price Index in § 4.10(D)(6)(i).

§ 4.10(D)(3) – Primary care alternative payment models. § 4.10(D)(3) on primary care alternative payment models is amended to recalibrate the primary care APM targets. Through dialog with primary

care providers and health insurers OHIC recognizes that the recent economic and workforce challenges facing primary care practices has slowed progress toward obtaining the targets as currently specified in regulation. OHIC maintains dialog with primary care practice groups in particular and is committed to working with them. Additionally, OHIC added a specific definition of primary care alternative payment model to § 4.3.

§ 4.10(D)(6) – Hospital contracts. Three substantive amendments are proposed to § 4.10(D)(6) which governs contracting terms between health insurers and hospitals.

The first proposed amendment states that "earned quality incentive payments shall become part of base payment rates." This amendment will ensure that hospitals are entitled to have earned quality incentive payments incorporated into base payment rates going forward.

The second proposed amendment sets forth a standard method which the commissioner will follow in making the annual determination of the Consumer Price Index for all Urban Consumers Less Food and Energy, which is the basis for establishing annual limitations on hospital price growth and population-based contract budget growth. The Standard Method is proposed as follows:

> *The US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase to be reported according to the Standard Method by the Commissioner shall be equal to the 12-month percent change in the CPI-Urban published by the United States Bureau of Labor Statistics in September of each year. The September report will reference the 12-month percent change from August of the prior year to August of the report year. Due to significant epidemiological or macroeconomic events the Commissioner may elect to utilize a different method of determining the value of the CPI-Urban Should the Commissioner elect to utilize a different method than the Standard Method, the Commissioner shall announce his or her intention of doing so by August 1 and allow for thirty days of public comment on the proposed method prior to issuing a final decision. If the Commissioner ultimately elects to utilize a different method than the Standard Method, any entity that submitted a public comment and is aggrieved by the Commissioner's determination may challenge the determination through all available methods of appeal.*

This proposal is the result of constructive dialog between OHIC and hospital leadership.

Third, OHIC is proposing to lower the quality-contingent rate threshold for prior approval of hospital contracts from fifty percent (50%) of the average rate increase to twenty-five percent (25%). This amendment to existing contracting rules will ensure that the hospitals are guaranteed a higher upfront percentage of annual average price changes during a time when hospital financial performance is being stressed by labor market conditions and inflation.

Conclusion

This paper has been prepared to facilitate the public's review of the proposed amendments to 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner, which includes the Affordability Standards. The proposed amendments will be posted for public comment. OHIC looks forward to reviewing the public's input on the proposed amendments.