OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

230-RICR-20-30-4 Proposed Amendments Regulatory and Cost-Benefit Analysis

Introduction

Overview.

The Office of the Health Insurance Commissioner (OHIC) was created by the Rhode Island General Assembly in 2004. The agency is charged with protecting consumers, ensuring fair treatment of health care providers, guarding the solvency of insurers, and improving the health care system as a whole.[1] OHIC has played a leading role in efforts to improve the affordability and quality of health care in Rhode Island. OHIC is proposing amendments to 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. Chiefly, the proposed amendments modify § 4.10 Affordable Health Insurance – Affordability Standards. The provisions of § 4.10 set forth regulatory standards for health insurers to follow in their efforts to improve the affordability of their products and undertake actions to improve health care quality and accessibility. OHIC developed these standards to meet its statutory mandate under R.I.G.L § 42-14.5-2, which states:

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

In light of pressing behavioral health needs of the public, during the 2018 session of the General Assembly, legislation was enacted modifying OHIC's powers and duties under R.I.G.L § 42-14.5-3 with respect to the promotion of integrated behavioral health. These provisions direct OHIC to:

[1] See RIGL 42-14.5-2 http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-14.5/42-14.5-2.HTM

(p) To work to ensure the health insurance coverage of behavioral health care under the same terms and conditions as other health care, and to integrate behavioral health parity requirements into the office of the health insurance commissioner insurance oversight and health care transformation efforts.

(q) To work with other state agencies to seek delivery system improvements that enhance access to a continuum of mental-health and substance-use disorder treatment in the state; and integrate that treatment with primary and other medical care to the fullest extent possible.

(r) To direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral health care delivery.

Since passage of the 2018 statutory changes, the COVID-19 pandemic and associated impacts on society have had a material impact on the behavioral health needs of the public, particularly among children and adolescents. The proposed amendments build on OHIC's prior work and are focused on increasing resources to better serve the behavioral health needs of children and adolescents, support efforts to measure and close health disparities, and ensure effective oversight of provider contracting practices and outcomes that impact the cost of health care and health insurance.

Background on the Affordability Standards.

The Affordability Standards were developed in 2008 by OHIC in consultation with its legislatively created Health Insurance Advisory Council. The Affordability Standards are a core component of OHIC's efforts to meet its statutory mission to improve the health care system, to protect consumers, and to improve the affordability of health insurance. As part of the annual rate review process for health insurance premiums, health insurers are required to prove that the rates filed for approval by OHIC are consistent with the proper conduct of the health insurer's business and the public interest. Given the public's interest in affordable health insurance, OHIC developed the Affordability Standards to systematize regulatory requirements for insurers to follow to demonstrate their efforts to improve affordability and quality.

Since 2010, the Affordability Standards have been modified from time to time. The present iteration of Affordability Standards, promulgated in 2020, comprises the following policies:

Standard One: Primary Care Spend Obligation

Requires that health insurer total medical payments made to primary care are at least 10.7 percent of annual medical spend, with 9.7 percent for Direct Primary Care Expenses. Indirect Primary Care Expenses must include at least a proportionate share for administrative expenses incurred to support and strengthen the capacity of a primary care practice to function as a medical home and to successfully manage risk-bearing contracts, and to support the health information exchange.

Standard Two: Primary Care Practice Transformation

Requires health insurers to support primary care practices that have achieved patient-centered medical home standards by providing ongoing payments to support care management.

Furthermore, the standards support the integration of behavioral health care into the primary care practice.

Standard Three: Payment Reform

OHIC's payment reform strategy includes the following key components: promoting population-based contracting, adoption of alternative payment models in primary and specialty care, measure alignment in provider contracts, improved hospital contracting practices, and limiting cost increases associated with population-based contracts entered into by Integrated Systems of Care (or, Accountable Care Organizations).

Summary of the Proposed Amendments

The proposed amendments chiefly modify § 4.10 and make other technical and non-technical changes to the regulation. The amendments embrace three new substantive policy areas:

1. 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%.
2. Health insurers will be required to include terms that relinquish the right of either party to contest the release of their contracts with professional providers, or parts thereof, to the office of the health insurance commissioner. The health insurance commissioner will periodically access these contracts for purposes of monitoring professional provider fee schedule increases, substantiating unit cost trend data filed as part of the health insurer's rate filing or assessing compliance with state laws and regulations adopted pursuant to Titles 27 or 42 in which the health insurance commissioner holds jurisdiction.
3. A new Health Equity subsection is created 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. This requires that health insurers obtain 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.

Further amendments beyond those enumerated above have been made throughout Regulation 4. These amendments do not create new policies. Rather, the amendments add form and structure to existing policies or change implementation schedules for some policies.

Those amendments which represent changes from the status quo, and which generate marginal costs or benefits are included in the analysis below. Of the amendments described above, the only one with significant economic impact on a five-year time horizon is the requirement that health insurers double their baseline per member per month expenditures on community-based behavioral health care for children and adolescents. This policy to promote increased investment in behavioral health care for

children and adolescents will form the focus of the CBA. The other two amendments described above will be addressed briefly.

Stakeholder Analysis.

For this analysis we distinguish between two major stakeholder groups: 1. Private market purchasers of health insurance and health care services; and 2. Health care providers. Rhode Island residents represent the basic entities with standing in this analysis. Individuals assume multiple economic roles, depending on the activities in which they engage. For example, a single individual may be a consumer, health care worker, and taxpayer. The proposed regulation influences costs and outcomes for Rhode Island residents who obtain insurance coverage through their employer or who purchase it directly from a Rhode Island insurer. The economic impacts of the proposed regulation are not confined to this group. Health care providers, particularly behavioral health care providers, are a significant stakeholder group whose interests will be affected by the proposed regulation. To the extent that economic impacts that accrue to providers are distributed to Rhode Island resident workers and owners of capital, the universe of individuals with standing will be broader than private market purchasers. It can be assumed that standing is co-extensive with the Rhode Island population.

The purchaser stakeholder group reflects Rhode Island's businesses, large and small, which either purchase a group insurance product from one of Rhode Island's major health insurers. The purchaser group also includes non-group, individual market consumers. Table 1 lists the major subgroups of purchasers and their relative sizes. The figures reflect Rhode Island resident enrollment in January 2022. The Medicaid and Medicare markets may experience spillover effects, but those spillovers are not assessed due to their indeterminant character.

Table 1: Purchasers

Purchaser Group	Group Size
Insured – Individual Market	40,623
Insured – Small Group Market	37,851
Insured – Large Group Market	62,771
Total	**141,245**

We do not have data on the number of health care providers, in particular, the number of community-based behavioral health care providers.

R.I. Gen. Laws §42-35-2.9 requires administrative agencies to conduct a regulatory analysis for proposed rules. The regulatory analysis must include an assessment of the benefits and costs of a "reasonable range of regulatory alternatives" reflecting the scope of the agency's discretion. Toward that end, the proposed amendments reflect the product of considerable research and stakeholder engagement by OHIC. Prior to drafting the proposed rule OHIC issued an Advance Notice of Proposed Rulemaking on November 23, 2021. The Advance Notice identified three areas for potential modification of the standards, including a behavioral health care spending requirement, health insurer community investment and health equity requirements, and a professional services provider rate cap. OHIC also solicited ideas beyond these proposals for consideration. OHIC received public comments from seventeen entities.

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Behavioral Health Care Expenditure Requirement.

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.

Alternatives:

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 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 primary care spending requirement. 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 a 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 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 on primary care.

Behavioral health care is a more heterogeneous class of services and incorporates a more diverse set of provider types than primary care. This creates a challenge when developing 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 payers. 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, broken down by setting of care and demographic strata that have policy significance. However, the core of the proposed amendment is to increase investments in behavioral health care for 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. For the reasons articulated in these documents, OHIC has chosen to undertake an initial focus on children and adolescents.

Data & Modelling Assumptions:

OHIC utilized available data through the Rhode Island All-Payer Claims Database (APCD) to calculate spending on behavioral health care in the fully insured commercial market. Behavioral health care spending was calculated in total, and further broken down into three classes: community setting (non-pharmacy), hospital setting (non-pharmacy), and pharmacy. Spending was also further stratified by age.

We estimate the impact of the proposal over a five-year period, 2024-2028. The analysis makes the following assumptions:

A.1. The per-member-per-month (PMPM) quantity is the ratio of total expenditures to member months. For the baseline scenario we assume numerator expenditure growth at an annual rate of 2% from 2019 spending. In the policy intervention scenario, we assume expenditure growth at an annual rate of 2% through 2023 and an annual rate of 2% from 2025 through 2028. We further assume that member months within the age stratum 0-18 is held constant at 2019 levels.
A.2. Service mix and technology are held constant throughout the analysis period.
A.3. The size of the private commercial market is fixed over time.
A.4. The membership mix between insurers is fixed overtime

Limitations:

This analysis faces key limitations which create uncertainty around the estimates of impact presented below. The principal limitations of this analysis are as follows:

1. The analysis utilizes claims data from the Rhode Island APCD. The data only represent claims data for Rhode Island residents. To the extent that insurers are making payments to behavioral health care providers outside of the claims system and funding programs that address mental health and substance use issues facing children and adolescents those expenditures are not captured in the analysis that follows. OHIC will include any non-claims payments in its baseline data collection in 2023 and those payments will form part of the expenditure target due to be activated in 2024.

2. To the extent that any of the assumptions or fixed parameters stated above are invalid, the estimates of impact presented below will be less valid. One example is the assumption that member months remains constant. For the period 2017-2019, member months for children and adolescents, age 0 – 18, were trending down, consistent with experience in the fully insured market segment as a whole. If the downward trend continues, all else equal, the aggregate marginal increase in spending will be lower than what is reflected in the cost schedule below.

Costs:

The schedule of costs is provided in Table 2 below. Years 2017 through 2019 PMPMs are based on APCD data. Baseline values for 2020 through 2023 are imputed using the assumptions described above. The proposed requirement is effective in 2024 and the five-year time horizon for the analysis of costs and benefits spans the years 2024 through 2028.

Table 2: Analysis of Changes in Expenditures for Community-Based Child and Adolescent Behavioral Health Care

Year	PMPM (Policy Proposal)	PMPM (Status Quo)	Difference	Member Months	Policy Impact
2017	$ 5.87	$ 5.87	$ -	454,808	$ -
2018	$ 5.89	$ 5.89	$ -	433,703	$ -
2019	$ 8.34	$ 8.34	$ -	408,564	$ -
2020	$ 8.50	$ 8.50	$ -	408,564	$ -
2021	$ 8.67	$ 8.67	$ -	408,564	$ -
2022	$ 8.85	$ 8.85	$ -	408,564	$ -
2023	$ 9.02	$ 9.02	$ -	408,564	$ -
2024	$ 18.05	$ 9.20	$ 8.84	408,564	**$ 3,612,898**
2025	$ 18.41	$ 9.39	$ 9.02	408,564	**$ 3,685,156**
2026	$ 18.78	$ 9.58	$ 9.20	408,564	**$ 3,758,859**
2027	$ 19.15	$ 9.77	$ 9.38	408,564	**$ 3,834,036**
2028	$ 19.53	$ 9.96	$ 9.57	408,564	**$ 3,910,717**

The proposal to have commercial health insurers increase 2023 baseline expenditures on community-based behavioral health care for children and adolescents is expected to increase expenditures by $3,612,898 in the first year (2024) and by $18,801,667 over a five-year period relative to the status quo.

The cost to health insurers for reporting this data should be small. Insurance companies employ data analysts and compliance professionals who will integrate the required reporting into existing workflows.

Benefits:

It is difficult to monetize the benefits that accrue to society from healthier children. Benefits are not necessarily realized within a five-year time horizon. The discussion that follows will describe benefits qualitatively. 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.[2]

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. Many of these benefits materialize over a time horizon of many years. In instances where benefits are garnered over the course of years, it is customary to represent the stream of benefits as a present value by utilizing a discounting methodology. We do not possess sufficient data to project benefit streams for purposes of representing present values.

Professional Provider Contact Terms.

Health insurers will be required to include terms that relinquish the right of either party to contest the release of their contracts with professional providers, or parts thereof, to OHIC. The health insurance commissioner will periodically access these contracts for purposes of monitoring professional provider fee schedule increases, substantiating unit cost trend data filed as part of the health insurer's rate filing or assessing compliance with state laws and regulations adopted pursuant to Titles 27 or 42 in which the health insurance commissioner holds jurisdiction.

Professional providers are those who bill professional claims using a CMS-1500 claim form.

Alternatives:

OHIC considered adopting a limitation on allowable average price growth for professional providers similar to the price growth cap currently applied to hospital contracts. This policy 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. Certain professional provider classes, such as primary care and behavioral health care, would have been excluded from the price growth cap. OHIC believes this proposal still has merit because provider price increases are passed on to consumers through the premium rate setting process and the potential for consolidation in the provider market that existed when OHIC issued the Advance Notice, and still exists, presents the risk that changes in market structure could increase health care costs without improvements in quality. However, in light of current significant labor market constraints facing professional providers and inflation rates running at forty-year highs, OHIC has decided not to adopt a professional services price growth cap at this time.

Costs:

[2] 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

There are no marginal costs due to this policy change. Health insurers will need to merely insert language in their professional provider contracts.

Benefits:

There are no immediate benefits of an economic nature that result from this policy change. The policy change will facilitate access to critically important contracting information by OHIC to monitor fee schedule changes, validate unit cost trend assumptions provided during the annual premium rate review process, and ensure that health insurers are following the laws and regulations. OHIC may utilize the information and data garnered from the review of contracts to develop policies that address prices and health care costs in the future.

Health Equity Requirements.

A new Health Equity subsection is created in § 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. 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.

Alternatives:

OHIC considered adopting a range of alternatives focused on the creation of a health insurer community investment requirement. The purpose of the requirement was to mitigate growth in health care costs while advancing health equity, addressing social determinants of health (SDOH), and improving population health. The alternatives were described in Next Generation Affordability Standards: Concepts, Rationale, and Additional Information which was released with the Advance Notice of Proposed Rulemaking in November 2021. In brief, the alternatives included:

- Community Benefit Activities – would have health insurers 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. OHIC would have defined "excess surplus."
- Community Investment Fund – would have required health insurers to contribute a defined amount of their excess surplus that is consistent with both the public interest and proper business conduct to a fund on an annual basis towards community initiatives that advance health equity, address SDOH, and improve population health.
- Investment Portfolio Allocation - would have required health insurers 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 chose to adopt rules that require health insurers to achieve NCQA Health Equity Accreditation or NCQA Health Equity Accreditation Plus by July 1, 2024. OHIC also chose to adopt demographic data collection principles and demographic data use principles derived from work being conducted by the

National Association of Insurance Commissioners (NAIC) Special Committee on Race and Insurance. Data collection will be used to identify health disparities. Ultimately, by January 1, 2026, health insurers must tie provider financial incentives to meaningful progress in remediating health disparities identified by the collection and use of demographic data.

Costs:

Health insurers will bear marginal costs due to the implementation of this proposal. There is a cost to achieve NCQA Health Equity Accreditation or NCQA Health Equity Accreditation Plus. The cost should be less than $10,000. Health insurers may need to invest in data collection, governance, and security measures to meet the demographic data collection principles and demographic data use principles set forth in the proposed amendments to Regulation 4. It is likely that these costs can be borne by existing staff and systems that are already built into administrative costs. Once health equity measures are integrated into health care provider incentive programs, providers will need to invest in methods and systems to collect data and track outcomes.

Benefits:

The proposed amendments will improve the data collection processes necessary to measure health disparities. Measurement of health disparities is critical and foundational to developing targeted evidence-based interventions through clinical practice, or public policy, to close disparities. In addition to improving individual and group outcomes on a host of health status measures, the closure of disparities can reduce health care costs, which benefits consumers.

Hospital contract quality programs.

Per the terms of 230-RICR-20-30-4.10(D)(6)(d) health insurers are required to include a quality incentive program in their contracts with hospitals. Furthermore, § 4.10(D)(6)(e)(2) requires the prior approval of the health insurance commissioner if less than fifty percent (50%) of the average hospital rate increase is for expected quality incentive payments. OHIC has proposed to make amendments to two provisions of these sections following discussions with Rhode Island's hospital leadership and the Hospital Association of Rhode Island.

First, OHIC is adding language that "earned quality incentive payments shall become part of base payment rates" to subsection 4.10(D)(6)(d)(3). This language will be added to clear up any ambiguity that earned quality incentives should carry forward in base rates. OHIC does not believe that the practice of backing quality payments out of base rates is prevalent, but the agency believed that clarity was important to the contracting parties.

Second, OHIC is lowering the quality-contingent rate threshold for prior approval of the contract 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.

Both of these amendments could lead to increases in hospital revenues, all else equal. In past CBAs OHIC has modelled increases in hospital revenues as transfers from payers (consumers) to hospitals. OHIC is unable to provide an estimate of changes in hospital revenue due to these changes because those

estimates would depend on reviewing existing hospital contracts, understanding existing and potential future quality performance among hospitals, and accounting for relative differences in hospital reimbursement rates.