



RHODE ISLAND'S HEALTH INSURANCE "AFFORDABILITY STANDARDS"

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THE RATE REVIEW PROCESS AND AFFORDABILITY STANDARDS

Generally, health insurance rate-review refers to the process by which a regulatory official is empowered to review, and subsequently approve or deny, health insurance rate increases.

"Rate" is generally synonymous with premium.

As part of its review, Rhode Island created four "affordability standards": additional requirements health insurers must meet to ensure that premiums and rates remain affordable to consumers.

ISSUE

Explain the affordability standards that are part of Rhode Island's rate-review process.

SUMMARY

The Rhode Island Office of the Health Insurance Commissioner (OHIC) reviews and approves or rejects health insurance rate increases proposed by health insurers.

In reviewing proposed rate increases, OHIC may consider the affordability of health insurance for consumers and whether the insurer has taken steps to increase affordability and met certain "affordability standards." Specifically, the standards require health insurers to:

1. increase spending on primary care;
2. adopt a patient-centered medical home (PCMH) model;
3. financially support the state's health information exchange (i.e., the transfer and sharing of electronic health information); and
4. adhere to certain quality of care and payment provisions, including an inflation cap on medical spending, when contracting with hospitals.



BACKGROUND

In 2004, the Rhode Island General Assembly created OHIC to regulate the state's health insurance industry. The Department of Business Regulation is responsible for regulating other types of insurance, including life and automobile insurance.

In 2009, OHIC established the first set of affordability standards, citing general statutory authority to, among other things, [ensure solvency, protect consumers, and improve the health insurance system](#) (R.I. Gen. Laws § 42-14.5 et seq.). According to OHIC, the standards were created with input from stakeholders, including health insurers. The standards were adopted in regulation in 2010 and last revised in February 2015 (R.I. Code R. § 32-1-2:1 et. seq.).

AFFORDABILITY IN THE RATE REVIEW PROCESS

As part of the rate-review process, OHIC may consider whether (1) an insurer's products are affordable to consumers and (2) the insurer has implemented strategies to increase health insurance affordability (R.I. Code R. § 32-1-2:9).

In determining whether an insurer's rates are affordable, the health insurance commissioner may consider any relevant affordability factors, such as:

1. trends, including historical rates for existing products and national and regional medical and health insurance trends;
2. inflation;
3. price comparisons to other market rates for similar products;
4. the ability of low-income individuals to pay for health insurance;
5. health insurers' efforts to control administrative costs; and
6. effective strategies implemented by health insurers to increase affordability.

In determining whether an insurer has implemented effective strategies to increase affordability, the commissioner may consider whether the insurer uses payment and delivery reform strategies, including the affordability standards (see below), and offers (1) a variety of consumer choices and (2) products that address the underlying cost of health care by creating appropriate and effective incentives for consumers, employers, providers, and the insurer.

The incentives include (1) focusing on primary care, prevention, and wellness; (2) actively managing chronically ill insureds; (3) encouraging cost effective medical settings; and (4) promoting evidence based quality care.

Finally, the commissioner may also consider the following four constraints on affordability:

1. state and federal requirements, such as benefit mandates;
2. medical services' costs over which plans have limited control;
3. health plan solvency requirements; and
4. the prevailing third-party payer system of health insurance and the resulting decrease in consumer price sensitivity.

AFFORDABILITY STANDARDS

OHIC, in considering whether an insurer's rates are affordable, may consider whether the insurer has met the four primary affordability standards (R.I. Code R. § 32-1-2:10). In general, the affordability standards apply to insurers with more than 10,000 insureds.

Standard One: Primary Care Spending

This standard originally required health insurers to increase medical payments ("primary care spending") made for direct primary care by 1% annually from 2010 to 2014. Insurers were prohibited from passing this increase on to insureds in the form of higher premiums. [According to OHIC](#), insurers increased total primary care spending from 6.3% in 2009 to 10.6% in 2014.

By 2014 direct primary care spending reached the targeted benchmark set by [OHIC](#), which then required health insurers to maintain this level by spending at least 9.7% of their annual medical expenses on direct primary care and at least 1% on indirect primary care (for a total of 10.7%) (R.I. Code R. § 32-1-2:10(b)(1)(A)).

[Direct primary care payments](#) directly benefit primary care practices and providers. [Indirect primary care payments](#) help primary care practices to function as PCMHs, and include support for Rhode Island's Chronic Care Sustainability Initiative and CurrentCare, the state's health information exchange. The health information exchange is a data system to electronically share confidential health information between providers.

Standard Two: Patient-Centered Medical Homes

[PCMHs](#) are places where insureds can receive care from a variety of specialists organized through their primary care physician. Rhode Island regulations require health insurers to offer incentives for primary care practices to become PCMHs.

The regulations require insurers take necessary steps so that 80% of primary care practices contracting with the insurer are functioning as PCMHs by December 31, 2019 (R.I. Code R. § 32-1-2:10(c)).

Standard Three: PCMH and the RI Health Information Exchange

Insurers must provide a proportionate share of the administrative expenses of the state-run PCMH initiative, which helps to train providers and offers other incentives for primary care practices to transition to the PCMH model (R.I. Code R. § 32-1-2:10(b)(1)(A)). They must also provide financial support for CurrentCare.

[OHIC reports](#) that CurrentCare has the potential to decrease the burden on primary care providers and increase health information sharing once a critical mass of patients agree to have electronic medical records shared on the system.

Standard Four: Payment Reform

This standard addresses price increases, efficiency payments, and quality standards in contracts between insurers and hospitals (R.I. Code R. § 32-1-2:10(d)).

Price Increases and Inflation. Insurers, when contracting with hospitals, cannot increase prices above the inflation rate, as measured by a national index, plus a certain percentage. They are generally barred from accepting contracts with price increases larger than the increase in the federal CPI-Urban, plus a certain percentage, which started at 1% in 2015 and decreases annually until 2018, when it reaches 0%.

Efficiency Payments. Contracts between insurers and hospitals must emphasize efficiency in treating patients. Insurers may offer performance bonuses, bundled payments, or other terms to reward efficient health care providers. They must also use payment systems that group medically similar individuals together (e.g., Diagnosis Related Groupings (DRGs) or population-based contracting). Under payment systems, insurers pay a per-patient rate for each grouping, regardless of the actual services provided to individual patients within the group. Such a system is intended to promote efficient health care because the provider is paid per-patient regardless of the services rendered to the patient.

By December 31, 2015, insurers were required to have at least 30% of their insureds under such a contract. They must have at least 45% by the end of 2016 and a percentage determined by the health insurance commissioner for 2017 and after.

Quality Standards. Insurers, when contracting with hospitals, must pay incentives to hospitals and providers who meet certain quality standards. The contracts must include a quality incentive program that pays providers for achieving or exceeding certain performance measures. In general, providers must meet performance measures in the CMS Hospital Value-Based Purchasing Program for Medicare. Contracts may also require providers to meet other nationally accepted clinical quality guidelines.

Inflation and Quality Payments Interaction. Although the inflation cap successfully limited price increases, a [2013 OHIC assessment report](#) notes that some hospitals used quality payment provisions to effectively increase payments beyond the inflation cap. As a result, OHIC prohibited contracts in which quality payments accounted for more than half of an average rate increase.

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