OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

2012 Provider Survey

September 2012

Introduction

The Rhode Island Office of the Health Insurance Commissioner (OHIC) conducts an annual survey that measures providers' experience with private insurance companies in support of its charge to ensure the fair treatment of providers. The survey focuses on payment rates, administrative workload, and provider relations with the three largest insurers in the state: Blue Cross Blue Shield of Rhode Island (BCBSRI), Tufts Health Plan (Tufts) and United Healthcare (United). Some questions ask providers to evaluate or rank the insurers in terms of performance and personal satisfaction, while others solicit specific comments.

OHIC designed the survey to give voice to the observations, sentiments, and perceptions of the health care system from a broad range of providers -- primary care physicians and specialists, sole practitioners and hospital employees. The survey informs OHIC's policy direction and allows practioners to draw attention to their needs as they relate to the commercial health insurance market.

Survey Highlights

General Provider Experience

- Overall, twenty two percent of respondents rated their satisfaction with insurance company provider services as "Good" or "Very Good". This rate varied by company, ranging from 9% at United to 38% at BCBSRI.

- Providers were more satisfied with BCBSRI payment rates (30% "Good" or "Very Good") than United (11%) or Tufts (20%)

Gauging Administrative Burden

- One-third of providers reported spending more than 30% of their time on insurer administrative work. Interacting with insurance companies to complete administrative tasks was frequently cited as burdensome, unnecessary and confusing.

- Respondents more positively viewed the *accuracy* than the *simplicity* of insurer claims processing. On a scale of 1 to 5, with 1 representing "Very Poor" and 5 representing "Very Good", respondents rated claims accuracy as 3.10 and simplicity as 2.86.

- Though insurance companies initially approve most claims, 62% of respondents reported that the companies later approve more than 40% of initially denied claims, indicating that most denials are due to administrative errors.

Health System Improvements

- Respondents had mixed views on how well insurance companies worked to improve the health system. 43% of respondents (with an opinion) rated BCBSRI's efforts as "Good" or "Very Good", compared to 13% at Tufts and 9% at United.

ABOUT THE SURVEY

Methods & Respondents

On May 14th, OHIC distributed the 2012 Provider Survey electronically to an email list of providers that the Rhode Island Department of Health maintains. Providers were sent four reminders before the survey closed on June 1st. OHIC received 426 responses (partial & complete) for a response rate of 19.7%.

Respondent Profile

- Specialties: Just under half (48% or 201 respondents) were primary care providers (defined as family medicine, internal medicine,
- or pediatrics).
- Caring for patients: Seventy-five percent of respondents (318 of 426) provide direct patient care during more than half of their working hours.
- Setting: Thirty percent of respondents practice in a hospital or other institutional setting. Another forty three percent practice in groups with fewer than ten physicians (18%, or 76 respondents, were sole practioners). The remainder prac-

Notes & Limitations

Several limitations should be stated upfront:

1.) The survey is not designed to allow OHIC to draw robust statistical inferences about the provider community in Rhode Island or scientifically uncover differences in the treatment of providers by the three commercial health insurers. Rather, it is a tool for translating provider experience into public knowledge.

2.) Providers' familiarity with administrative decisions varies widely. The physicians working in a small practice may closely follow fee schedule changes and have intimate knowledge of the differences in insurance company practices. Academics, salaried physicians, and others may have a narrower view of the commercial insurance market and may be more likely to respond with "Not Applicable", or "Don't Know".

In the following analysis, we removed these responses and re-scaled the remainder, noting the number of "Not applicable" or "Don't Know" responses we discarded. Approximately 15% of respondents were not practicing physicians and were likely retired, working in an administrative role, or in academia.

3.) **Finally, the insurers referenced in this survey have widely different market shares.** Blue Cross Blue Shield of Rhode Island (BCBSRI) represents approximately 71% of these covered lives, United Healthcare holds 26% and Tufts, which entered the market in 2009, holds 3%. Because of Tufts' small commercial membership in Rhode Island, providers may have less experience with this company, which is reflected in higher numbers of "N/A" or "Don't

Key Terms

Reimbursement rates: The negotiated amount that insurers pay providers for the services they deliver

Administrative activities: Tasks, other than medical care, that a practice's employees perform to ensure proper reimbursement and high quality care

Prior Authorization: To ensure appropriate use of drugs and services, many insurance companies require providers to request approval before performing certain care.

Denials: Insurance companies pay providers for all approved claims. The company may deny claims if, for example, the patient is not an active member or the provider submits incorrect information

About OHIC

The Office of the Health Insurance Commissioner (OHIC) was established by legislation in 2004 to broaden the accountability of health insurers operating in of Rhode Island. Under this legislation, the Office is dedicated to:

1. Protecting consumers
2. Encouraging fair treatment of medical service providers
3. Ensuring solvency of health insurers
4. Improving the health care system's quality, accessibility and affordability

The Office sets and enforces standards for health insurers in each of these four areas. It is the only state agency in the country that specific oversees health insurance.

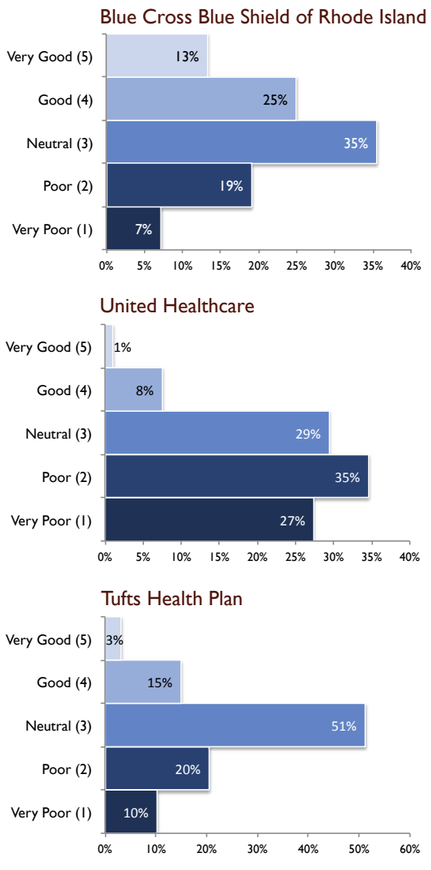
1. General Provider Experience

Interacting with insurance companies is a critical part of a provider's day. In Rhode Island, approximately 88% of patients have insurance and 69% of those are covered by the three largest commercial insurers that are the focus of this survey. Practices, which include everyone from the physician to the billing and front desk staff, coordinate with their patients' insurance companies to receive their payments, to understand which drugs and services a patient's insurance will cover, and to gain authorization to perform certain procedures.

Because most providers work with a variety of insurers, they can compare how these companies (facilitate) the delivery of high quality, cost-effective care. How well do the insurers meet the needs of patients and providers?

Q How would you rate your level of satisfaction or dissatisfaction with general provider services (responding to inquiries, communications, etc.) for each health plan?

A



Score: **3.18**

Number of N/As: 85 of 378 (22%)

Score: **2.20**

Number of N/As: 86 of 378 (23%)

Score: **2.80**

Number of N/As: 124 of 378 (33%)

What do the Scores mean?

In order to compare how providers rated each company, we calculated a score for each company based on provider response.

We first multiply the value of each response -- "very good" is worth 5 points, for instance -- by the number of providers who chose that response.

We then divide the sum of the multiplication by the total number of response, which gives us a weighted average final score.

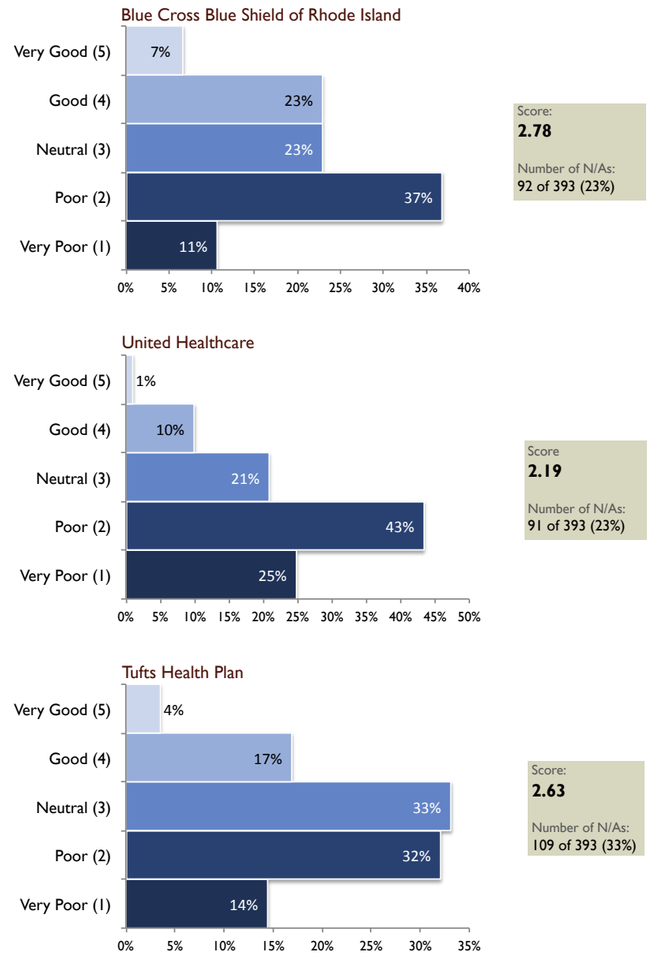
I. General Provider Experience

Providers were asked to rate the adequacy of rates each health plan pays them for individual services, capital (such as electronic health records), or patients (i.e. capitation arrangements). Providers and payers negotiate these rates on a regular basis, though in practice, small groups and solo physicians may have less ability to affect the final amount. The percentage of providers who reported that their payments were "good" or "very good" was 30% for BCBSRI, 11% for United, and 21% for Tufts.

> "Rates continue to be poor relative to [the] cost of doing business, [rates of] taxation, and relative payments in neighboring Mass and Connecticut."

Q How would you rate the adequacy of reimbursement rates paid to you from each health plan?

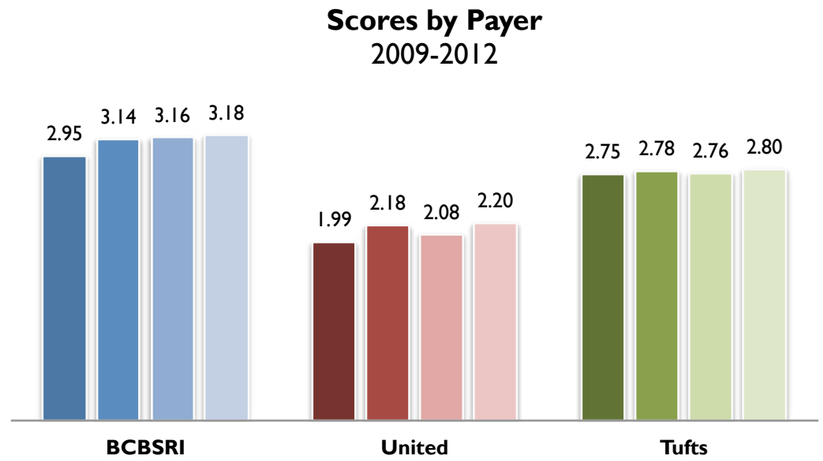
A



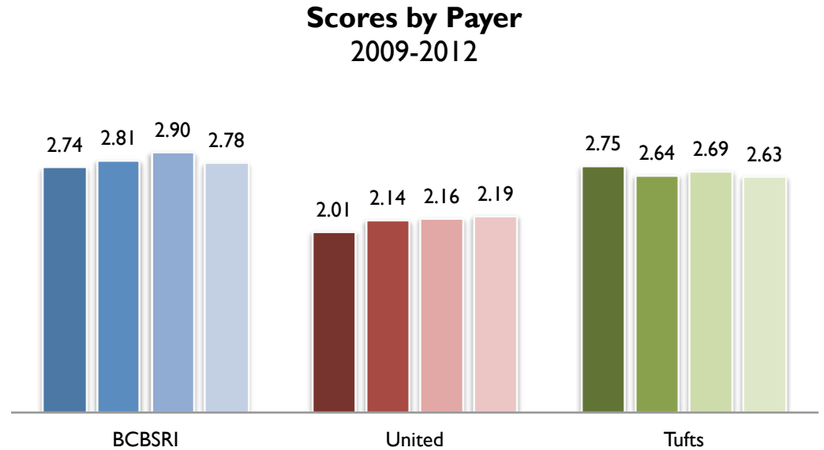
I. General Provider Experience: Historical Trends

How have providers' views changed over time? OHIC administered similar versions of this survey in each year from 2009-2012 and the following charts and those on pages 9 and 11 show each payer's scores for every issue of the survey.

Q How would you rate your **level of satisfaction** or dissatisfaction with general provider services (responding to inquiries, communications, etc.) for each health plan?



Q How would you rate the **adequacy of reimbursement** rates paid to you from each health plan?



II. Gauging Administrative Burden

The quality of a health plan's provider services, as well as the accuracy and simplicity of claims processing, affect the administrative workload providers bear. The following questions ask providers to gauge the magnitude of this burden. Though some administrative work is necessary to generate revenue and keep patient records organized, uncoordinated and cumbersome administrative processes compromise a practice's ability to deliver high-quality care.

> "We spend an inordinate amount of time trying to get authorizations for medications or procedures that, as a practioner, is my best medical opinion for the patient."

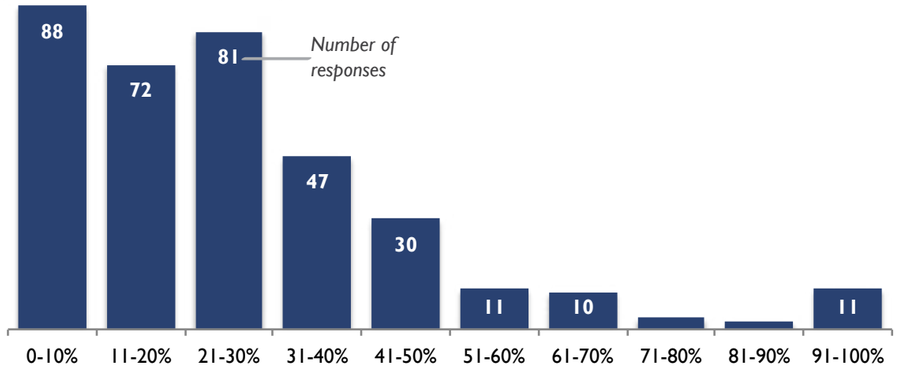
Q On average, what percent of your practice's total operational hours are dedicated to insurer administrative work (claims billing, claims adjudication, prior approvals, other utilization review, etc. *excluding patient claim collection*)?

A

Two thirds of providers report that their office spends less than 30% of its time on administration

One third of providers report that their office spends between 30% and 100% of its time on administrative work.

Responses at the extreme end of this spectrum may reflect the work of billing professionals in a practice's office, which is often outsourced



> **"The telephone wait time for all insurers is dismal.** We have had to wait up to 45 minutes in some circumstances just to have someone answer the phone. In addition, the person who answers does not always have the information we need to proceed. Ergo another phone call, another wait."

II. Gauging Administrative Burden

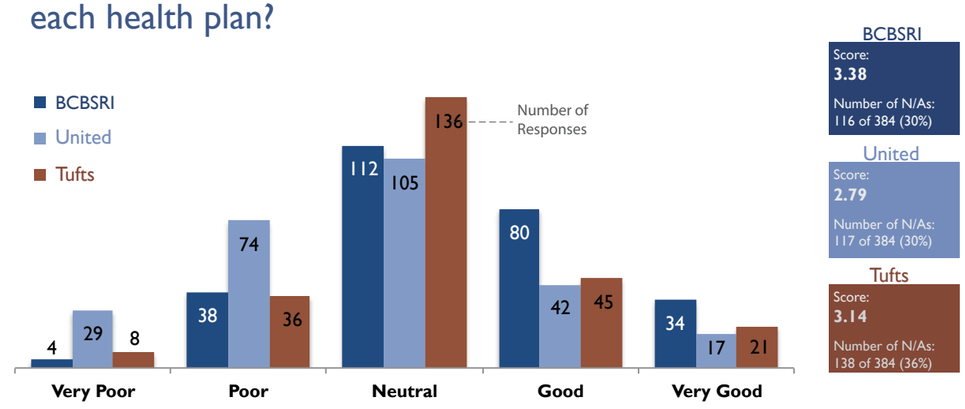
The survey then asked providers to rate the accuracy and simplicity of insurer claims processing.

> "Sometimes the process is smooth and easy. Other times it is a nightmare of repeated phone calls."

Claims processing refers to the way a health plan receives, reads, and pays for a service (claim) that a practice provided. *Accuracy* means whether reasons for denial or other questions reflect the practice's actual claims submission. *Simplicity* refers to how intuitive providers find the claims submission and adjudication process. On both dimensions, BCBSRI received the highest score, followed by Tufts and then United.

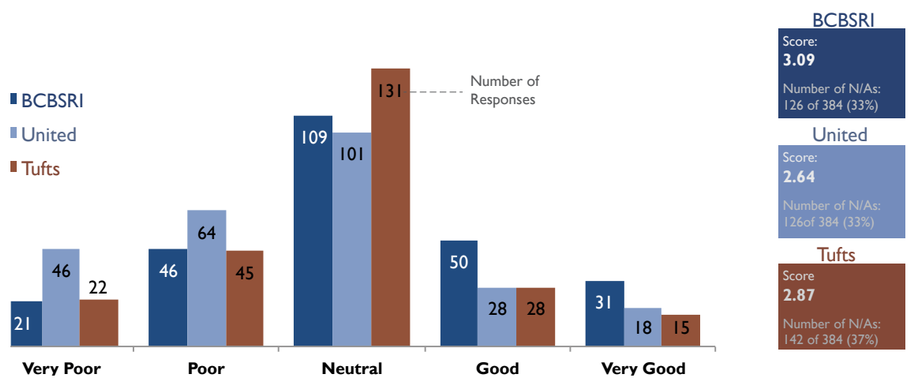
Q How would you rate the **accuracy** of claims processing for each health plan?

A



Q How would you rate the **simplicity** of claims processing for each health plan?

A



II. Gauging Administrative Burden

Claims that are initially denied and later approved reflect a faulty administrative process on both the part of the provider and insurer. These claims are generally denied because of coding errors, insufficient documentation, and other technicalities.

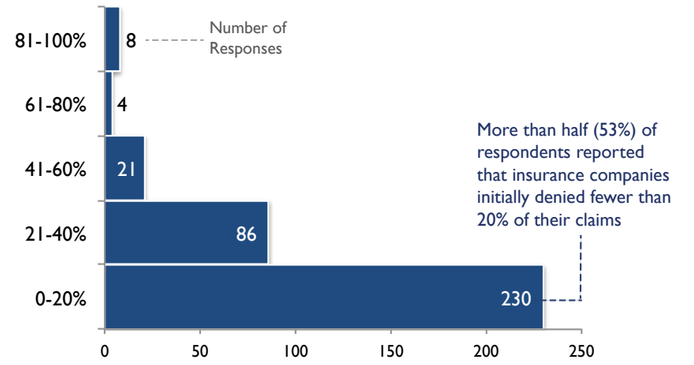
The survey asked providers for the percentage of claims that are initially denied by an insurance company. Most claims are approved: over half (53%) reported that insurers initially deny fewer than 20% of their claims. However, 62% of respondents reported that insurance companies later approved claims they initially denied more than 40% of the time.

> "The appeals process for denied claims is cumbersome and costly. To send claims is a fairly easy process. It's getting them paid and/or paid accurately which is the difficult part."

> "We are very persistent, otherwise our percentage of approved denials would be much [lower]."

Q On average, what percent of claims are **initially denied** by an insurance company?

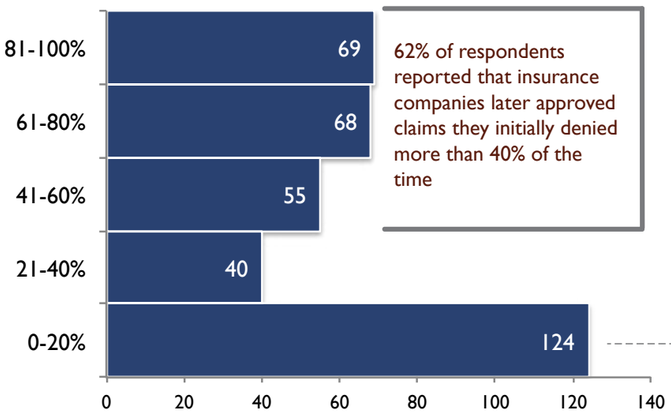
A



More than half (53%) of respondents reported that insurance companies initially denied fewer than 20% of their claims

Q On average, what percent of denied claims are **later approved**?

A



62% of respondents reported that insurance companies later approved claims they initially denied more than 40% of the time

Reasons For Denial

"Pre-authorization continues to be an issue with all plans, and we have hired additional staff to aid in the process of facilitating referrals."

"Every company has a different way of doing business"

"Not a covered service (when the service is covered), out of network provider (when we are an in-network provider)"

"Prior authorization"

"Patient no longer covered by company"

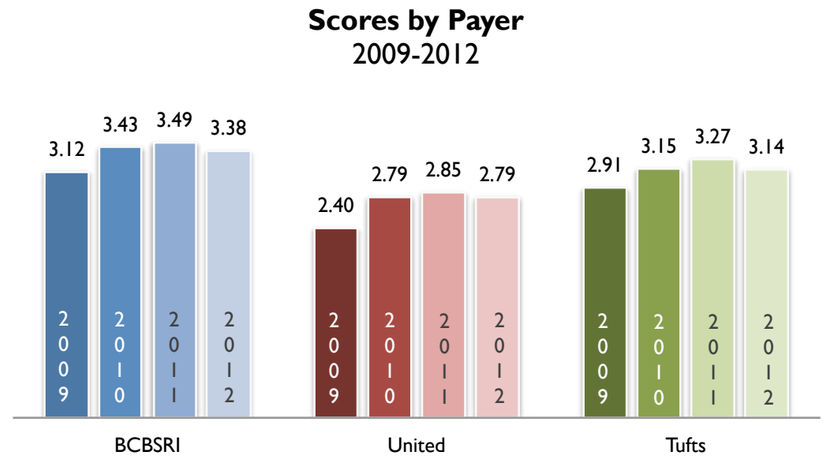
"Coding changes"

"Restrictions -- that are not in the best interest of patients -- on the use of medications"

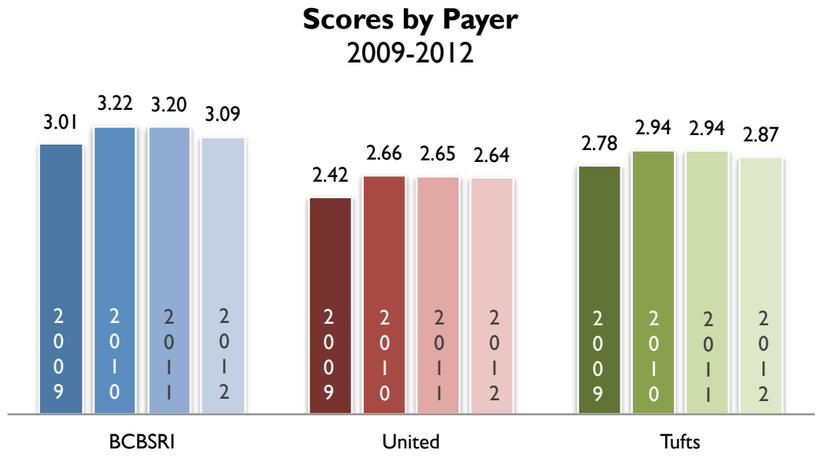
II. Gauging Administrative Burden: Historical Trends

The following charts show how providers' view of two aspects of administrative burden have changed over time, based on OHIC 's 2009-2012 surveys. Because OHIC first introduced the questions regarding denials (page 8) in 2012, there is not yet trend information for those issues.

Q How would you rate the **accuracy** of claims processing for each health plan?



Q How would you rate the **simplicity** of claims processing for each health plan?



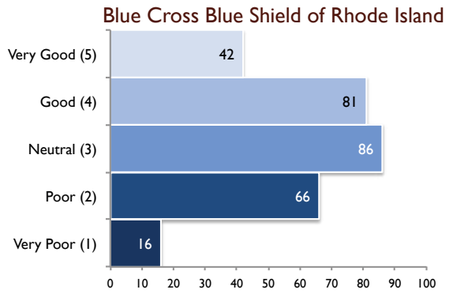
III. Health System Improvements

Health system improvements require the collaboration and cooperation of stakeholder across the health care system. We asked providers to rank the three insurers' efforts to promote improvements in the state's health care system. BCBSRI's efforts received the highest score, followed by Tufts and then United.

> "Thank you very much for reading all this. I have to go see pts!"

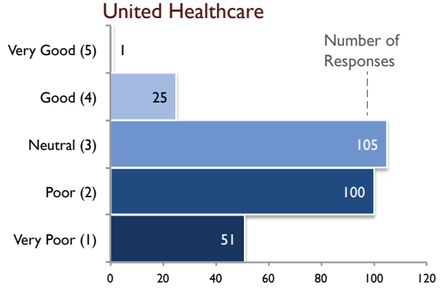
Q How would you rate each health plan's efforts to promote improvements in Rhode Island's health care system?

A



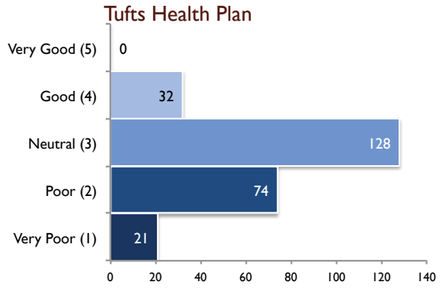
Score: **3.23**

Number of N/As: 84 of 375 (22%)



Score: **2.38**

Number of N/As: 93 of 378 (25%)



Score **2.67**

Number of N/As: 120 of 378 (32%)

Q: Please provide any additional comments or feedback not previously stated.

A: "Give us or patients lists of their covered meds and tiers so we can figure out what to prescribe"

"Blue Cross seems very committed to improving the quality of care transitions in the state, which is incredibly important for patients and, when done well, can accrue cost savings to health plans."

"High deductibles cause patients to avoid care. Then by the time they come in they are ill, at times requiring a higher level of care."

"More coverage of healthy lifestyle - nutritionists, psychiatric support for weight loss... [we] need lifelong changes to prevent disease. Encourage docs financially to spend more time with and listening to patients!'

"Let [the] docs speak to docs or pharmacy when we get on phone. Make [the] process... medically relevant."

"Have the insurer pay the physician at the contracted rate and have the insurer get the copay from the patient. [P]ut insurance pay on the financial field where it belongs and not interfering with the actual practice...of medical care"

III. Health System Improvements: Historical Trends

Since 2009, providers' view of health plan commitment to system improvement has increased for each of the companies. During this period, health plans have invested in meaningful projects to bolster the state's health care deliver system, including:

- **Patient centered medical homes** -- both the state's model (Chronic Sustainability Initiative of Rhode Island) and their own programs
- **Currentcare**, the state's health information exchange, to mobilize healthcare informatics
- **Loan forgiveness** programs for primary care providers
- **Electronic health record** in provider practices to support coordination of care

Q How would you rate each health plan's efforts to promote improvements in Rhode Island's health care system?