

Affordability Standards

Office of the Health Insurance Commissioner
November 2011



Protecting Consumers Ensuring Solvency Engaging Providers Improving the System

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Executive Summary

As Rhode Island struggles with a weak economy and health insurance premiums rise at a faster pace than overall inflation rates, commercial health insurance enrollment in Rhode Island has declined by approximately 10% while the number of uninsured has increased by this same amount. Rises in medical expenses - which include both an increase in prices and utilization of services per capita - have driven the rise in insurance premiums and are in part responsible for the decline in commercial enrollment. These forces are not unique to Rhode Island but can be addressed locally. The Office of the Health Insurance Commissioner's Health Insurance Advisory Council published a report in 2009 to examine these medical expense drivers and propose priorities for the state's insurers that would encourage a systemic expense reduction. The report – consistent with the statutory direction for the Office – set forth a set of Affordability Standards, directing commercial insurers to improve the affordability of health care in Rhode Island by:

- 1. Expanding and improving the primary care infrastructure in the state - with limitations on ability to pass on in premiums;*
- 2. Spreading the adoption of the chronic care model-style medical home;*
- 3. Standardizing Electronic Medical Record incentives; and*
- 4. Working toward comprehensive payment reform across the delivery system.*

The Affordability Standards went into effect in 2010 and further clarification of Standard Four was issued later that year in the form of hospital contracting conditions.¹

This report assesses insurer performance in implementing these standards and suggests observations about the future direction of the standards. In general, the Affordability Standards are being implemented and are changing the nature of health insurers and provider contracting. This is a significant accomplishment. More specifically, for Standard 1, all health plans met their increased 2010 primary care spend goals, albeit using different priorities. The three health insurers also continue to participate in the All-Payer Patient-Centered Medical Home project set in Standard 2. All three commercial insurers have attested to the availability of Electronic Health Records incentives in Standard 3. Standard 4, “working toward comprehensive payment reform” has proved to be more difficult to assess. Compliance with the six conditions of this standard varies by insurer but appear to be met. OHIC will continue to strengthen insurer consent to the conditions and investigate insurer-specific enforcement actions for non-compliance.

In summary, public priorities for insurers can be set to improve health care affordability and insurers can be held accountable for meeting these priorities. While this report demonstrates that the Affordability Standards are being implemented, it is too early to assess their ultimate effectiveness in changing medical expense trends. As implementation and refinement of the Standards continues, future considerations for this work include providing resources for further monitoring and evaluation of the standards.

¹ Specifically, after a study performed by OHIC concluded a lack of payment reform initiatives between hospitals and insurers, six conditions were attached to 2011 rate factor decision which included: (1) using units of service that encourage efficient resource use, (2) using the Medicare CPI as the rate of increase, (3) implementing quality incentives, (4) administrative simplification, (5) care coordination, and (6) transparency.

Context

During the past five years, the number of people with commercial health insurance in Rhode Island has declined by 50,000 or 10%, while the number of uninsured Rhode Islanders has grown by roughly the same amount (Figures 1 and 2).

Figure 1²

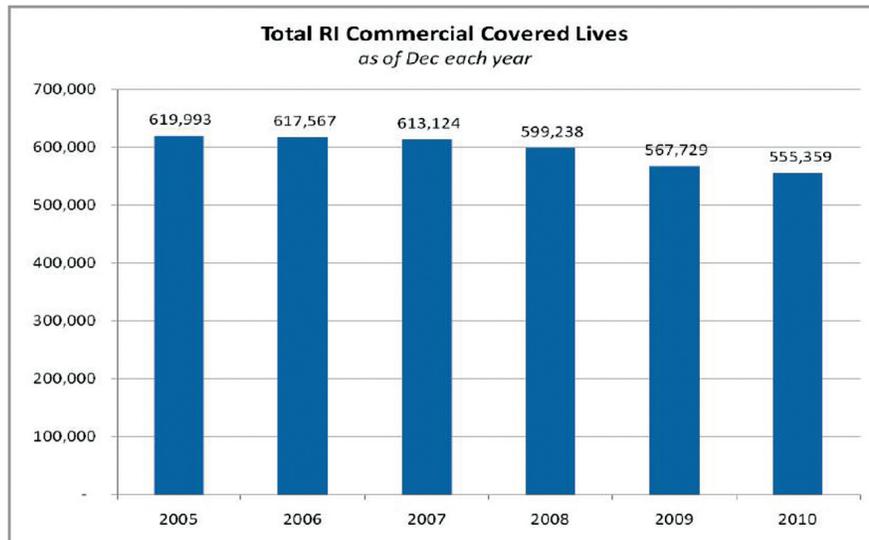


Figure 2³

Table 2. Historic Average Annual Estimates of Uninsured Rhode Islanders and Projection to 2010

| | 1999-2001 | 2000-2002 | 2001-2003 | 2002-2004 | 2003-2005 | 2004-2006 | 2005-2007 | 2006-2008 | Projected 2010Q1 |
|--------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------------|
| Number of uninsured | 71.0 | 82.7 | 92.7 | 103.3 | 110.7 | 106.3 | 107.3 | 107.3 | 140.1 |
| Percent of population | 8.1% | 9.3% | 10.3% | 11.3% | 12.0% | 11.5% | 11.6% | 11.7% | 15.8% |
| <i>Unemployment rate</i> | 4.1% | 5.1% | 5.4% | 5.2% | 5.1% | 5.0% | 5.2% | 7.8% | 12.0% |

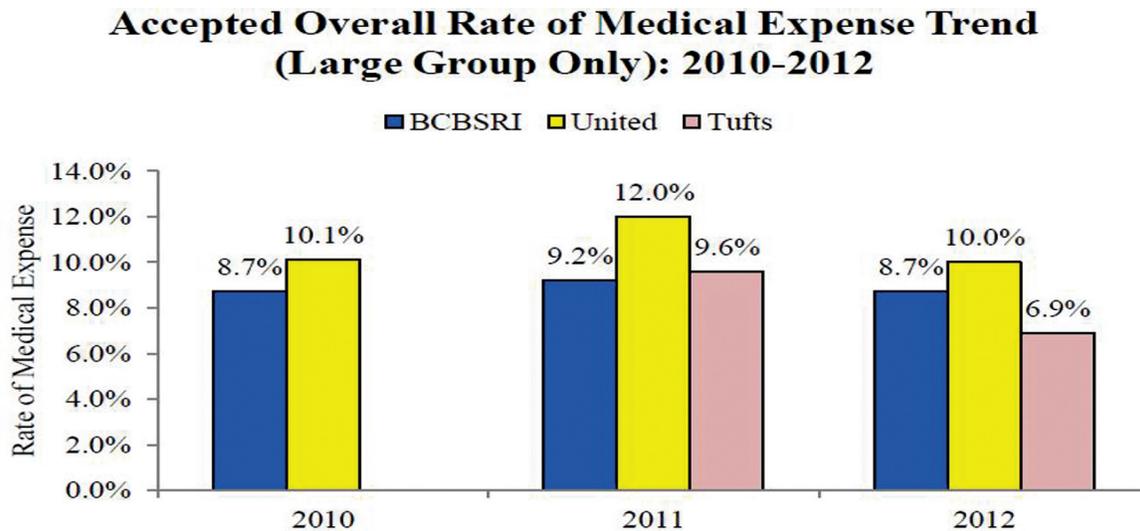
Although Rhode Island's weak and shifting economy has reduced the number of jobs offering health care benefits, the rate of increase in commercial health insurance premiums has also been driving the decline in enrollment. The last three years have seen predicted commercial medical expense trends of approximately 9% even though overall inflation rates hover in the 1-2% range (Figure 3).

²Source: Analysis of Rhode Island Commercial Insurance Enrollment Trends by Line of Business and Carrier as of December 2010. Available at: <http://www.ohic.ri.gov/documents/Insurers/Reports/2010%20RI%20Commercial%20Ins%20Enrollment/RI%20Commercial%20Insurance%20Enrollment%20Trends.pdf>

³Source: Study of Rhode Island's Uninsured, March 11, 2010. Available at:

http://www.ohic.ri.gov/documents/Insurers/Reports/2010%20Uninsured%20Study%20Report/1_Mathematica%20Final%20Report.pdf

Figure 3⁴



The commercial medical expense trend is driven by increases in both prices and utilization of services per capita, as indicated by one insurer’s recent rate filing (Figure 4). The percent increases in each of these categories (hospital inpatient, outpatient, pharmacy, primary care, and all other care) are greater than the increases in overall inflation.

Figure 4⁵

2012 Requested Rate Factors for BCBSRI Large Group

| | Annual Rate of Price Inflation | Annual Rate of Utilization and Other Items Inflation |
|------------------------|--------------------------------|--|
| Category | | |
| Hospital Inpatient | 5.7% | 0.7% |
| Hospital Outpatient | 5.3% | 4.5% |
| Pharmacy | 3.6% | 7.3% |
| Primary Care | 9.4% | 4.2% |
| All Other Medical Care | 2.5% | 4.2% |

⁴Source: OHIC rate factor filings

⁵Source: Rate Factor Review Template 2012 with Approved Rates. Available at:

http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2011%20Rate%20Factor%20Decision/3_Rate%20Factor%20Review%20Template%202012%20with%20approved%20rates.pdf. In this report, OHIC uses the actuarially justified predictions if future expenses – based on past experience – as a proxy for historical measurement.

History of OHIC's Affordability Standards

The Office of the Health Insurance Commissioner's (OHIC) Health Insurance Advisory Council (HIAC)⁶ recognized that increases in health insurance premiums are driven by the systemic nature of medical expense trends, not merely a presence or absence of insurer competition. In 2009, the HIAC conducted an extensive review of options to address these cost drivers and developed the "Affordability Standards and Priorities for Rhode Island Commercial Health Insurers" report which articulated systemic expense reduction priorities for the state's insurers and, by extension, providers and other purchasers. HIAC directed insurers to *"improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:*

1. *Expand and improve the primary care infrastructure in the state - with limitations on ability to pass on in premiums*
2. *Spread adoption of the chronic care model-style medical home*
3. *Standardize Electronic Medical Record incentives*
4. *Work toward comprehensive payment reform across the delivery system.*⁷

Payment reform was targeted in the Affordability Standards because provider payment is a critical function of health insurers and the current fee-for-service payment system is generally considered to result in poor care coordination and excess utilization of services. While OHIC and health insurers have worked since the release of the Affordability Standards to implement these priorities, this fourth area of focus has proven to be the most challenging to execute. Hospitals constitute about 40% of a health insurer's medical expenses and depending upon the institution, they can have significant leverage in private contracts because of service market share. However, hospitals may also bear costs associated with teaching, charity care, and alleged underpayments by public payers. Additionally, hospitals are significant employers in their respective communities. For all these reasons, hospital payment reform is both financially important and practically difficult.

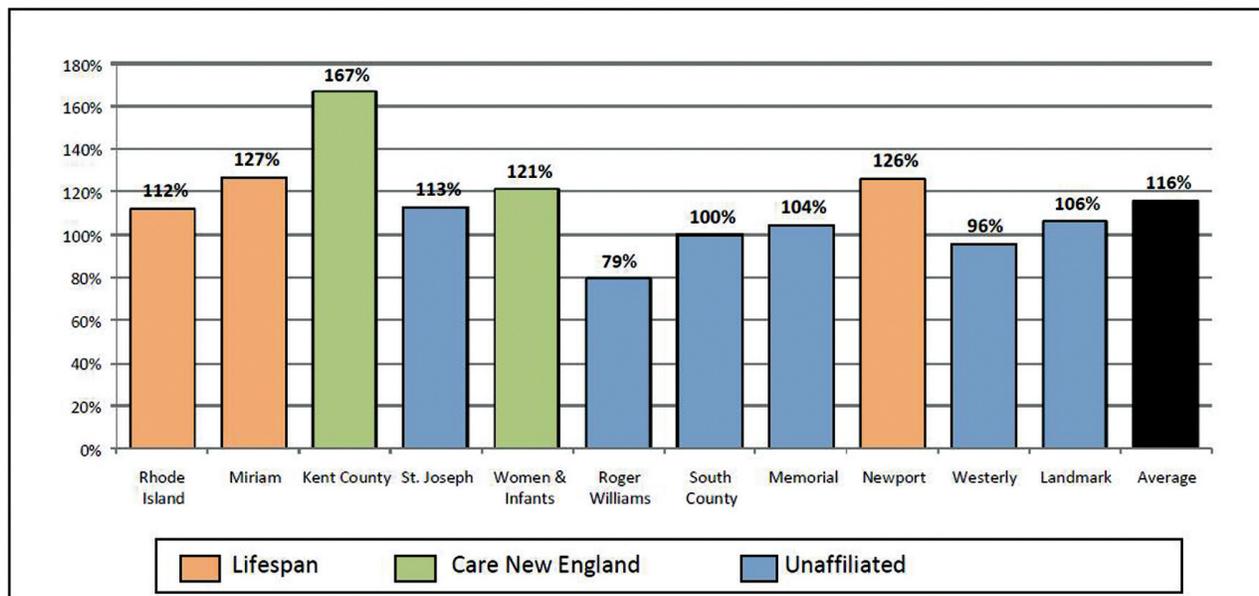
In January 2010, an analysis by OHIC documented significant discrepancies in rates of payment for inpatient medical and surgical conditions among institutions, even after adjusting for condition severity, uncompensated care and hospital teaching responsibilities (Figure 5).⁸

⁶The HIAC is a statutorily mandated advisory group to OHIC, comprised of businesses, providers, and consumers.

⁷System Affordability Priorities and Standards for Health Insurers in Rhode Island, April 2009. Available at: http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%205_HIAC%20Report%20-%20System%20Affordability%20Stds%20&%20Priorities%20for%20Insurers.pdf

⁸Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island, January 2010. Available at: <http://www.ohic.ri.gov/documents/Insurers/Reports/2010%20Hospital%20Payment%20Report/2010%20Variations%20in%20Hospital%20Pmt%20Rates.pdf>

Figure 5: CY2009 BCBSRI and United Inpatient Medical/Surgical Payments Indexed to Medicare



While these were measures for a single point in time, the implications for health insurance affordability were significant – raising questions regarding how could some hospitals remain financially viable on much smaller payments from carriers, and how such payments were negotiated.

In June 2010, a survey conducted by OHIC, performed in conjunction with its annual review of filed health insurer rate factors, documented the lack of payment reform initiatives between commercial insurers and providers in terms of units of payment or performance incentives.⁹ Figure 6 summarizes the self-reported state of health insurers’ contracting practices and indicates the challenges of achieving the HIAC’s comprehensive goal of payment reform.

⁹Provider Contracting Services, April 2010. Available at: http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010%20May_Provider_contracting/Provider%20Payment%20Survey%20Compilation.pdf

Figure 6

| | BCBSRI | United | Tufts |
|---|--|---|---|
| Inpatient Contracts | (11 total) | (8 total) | (8 total) |
| Unit of Payment for Services* | 3 – DRG 9 – Per diem 1 – % of Charges 9 – Other (case, global liability etc.) | 2 – DRG 6 – Per diem 2 – Case rate | 2 – DRG 5 – Per diem 3 – % of charges |
| Quality or Customer Service Incentives in Contracts?* | 3 – No incentives; 9 – Yes Range of % of total on incentive payments = 0.4 – 3.0% | 8 – No incentives | 5 – No incentives; 3 – yes Range of % of total on incentive payments = 0.3 – 1.0% |
| Utilization Incentives in Contracts? | 9 – No incentives 2 – Global | 8 – No incentives | 7 – No incentives 1 – Day reductions (1.5% of total payments for IP services in CY 09) |
| Provision for Additional Outlier Payments and/or Severity Adjusters | 6 – No 3 – Charge threshold 1 – Length of stay 1 – Not specified | 8 – No | 2 – No 4 – yes, to outlier provision |
| Provision for Additional Payments to Attain Revenue Targets | 11 – No | 8 – No | 8 – No |
| Hospital Outpatient Contracts | | | |
| Unit of Payment for Services* | 9 – Procedure Based methodology 2 – Global Liability | 8 – Procedure Based methodology | 8 – Procedure Based methodology |
| Quality or Customer Service Incentives in Contracts?* | 2 – No incentives; 9 – Yes Range of % of total on incentive payments = 0.4 – 3.0% | 8 – No incentives | 5 – No incentives; 3 – Yes Range of % of total on incentive payments = 0.3 – 1.0% |
| Utilization Incentives in Contracts? | None | None | None |
| Professional Services Contracts | | | |
| Number of Contracts | Top 10 | Top 10 | Top 10 |
| Unit of Payment for Services* | 10 – Procedure Based methodology | 10 – Procedure Based methodology | 10 – Procedure Based methodology |
| Quality or Customer Service Incentives in Contracts?* | 6 – No incentives 4 – Yes Range of % of total on incentive payments = 1.0 – 14% | 10 – No incentives (United practice rewards program pays for achievement of standards based on combination of quality and utilization measures) | 7 – No incentives 3 – Yes Range of % of total on incentive payments = 2.5 – 5.0% |
| Utilization Incentives in Contracts? | 1 – Use of pharmacy services 1 – Overall efficiency of care 8 – No incentives | 10 – No incentives | 2 – Visit/Volume reductions 2 – Use of RX services 1 – Other 7 – No incentives |

*Contracts may have more than one unit of payment for services

As a result of these reports and findings commercial insurance rate factors for 2011 approved by the Commissioner in 2010 carried six conditions for health insurers' terms in their new and renewing contracts with hospitals:

1. **Units of Service:** pay for inpatient and outpatient services using units of service that encourage efficient resource use (e.g. Medicare DRGs and APG's – same as RI Medicaid or more innovative)
2. **Rates of Increase:** Medicare CPI (same standard as Medicaid in RI)
3. **Quality Incentives:** mutually agreed to quality incentives based on nationally accepted measures worth at least an additional 2% of revenue
4. **Administrative Simplification:** terms that define mutually agreed to obligations
5. **Care coordination:** terms that promote and measure improved clinical communications
6. **Transparency** for these six terms¹⁰

The conditions were to be in place for at least a year and then subject to further review.

Objective of this Report

The Affordability Standards went into effect in 2010. Standard 4 was further clarified with the implementation of the hospital contracting conditions on July 1, 2010. Since the inception of the standards, OHIC has worked to monitor their implementation by the insurers. With 18 months of experience, this implementation may be initially evaluated for progress – if not yet for its effectiveness. The purpose of this report is to assess health insurer performance in implementing these standards and to make some preliminary observations about the future role of the standards. This report is not a substitute for a more formal analysis of the efficacy and appropriateness of the standards, but rather an interim assessment of insurer performance to maintain accountability.

Standard One: Primary Care Spend Targets

Monitoring Methods

OHIC has invested a considerable effort in developing a common template for measuring and reporting primary care spend information in conjunction with insurers. OHIC collects this information every quarter and meets with insurers individually to review past performance and plans for meeting future spend targets on a quarterly basis. Periodically, OHIC has compiled and shared this information with its Health Insurance Advisory Council. At the insurers' request, the HIAC conducted a public process to give additional guidance on the definition of primary care spend and the priorities for 2011 as the insurers developed their plans.

Assessment of Compliance

Figure 7a summarizes health insurers actual primary care spend for the 2008 base year, the first performance year of 2010, and the spend targets for 2011 and 2012 as a percentage of total medical spending. Figure 7b represents actual primary care spend amounts in dollars. Figure 7c shows the forecasted categories of primary care spending in which they carriers will invest. BCBSRI proposed to increase their primary care spend by investing in a medical home initiative and United will make improvements to their fee-for-service payment system.

¹⁰Full text of the conditions is available at:
http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2010_July_Rate_Decision/2_%20Conditions%20Summary.pdf

Figure 7a¹¹

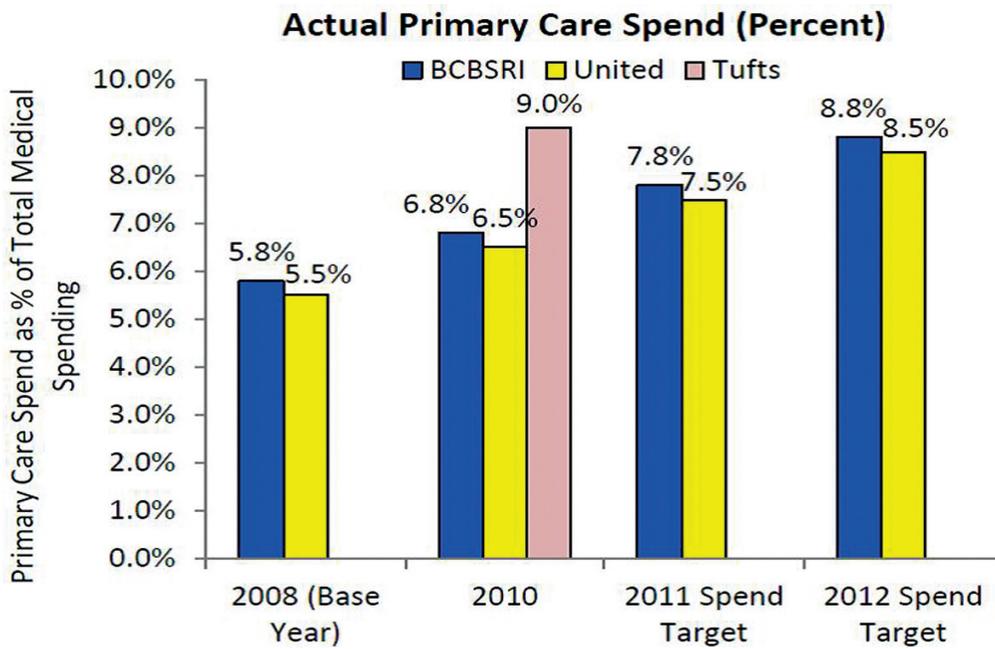
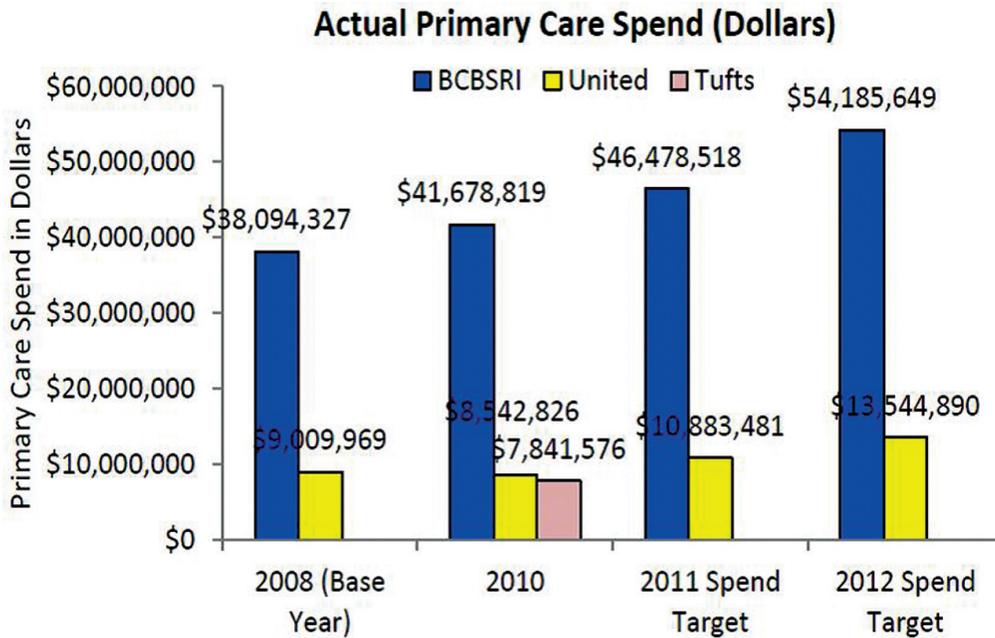


Figure 7b



¹¹Tufts reports its primary care a every 6 months.

Figure 7c

Forecasted Contributions in Primary Care Spend for 2011 by Carrier

| Category* | BCBSRI | UHCNE |
|----------------------------------|---------------|--------------|
| FFS Improvements | 10% | 39% |
| Medical Home (CSI & Proprietary) | 60% | 13% |
| EMR subsidy | 12% | 10% |
| Other Allowable | 19% | 38% |

*Loan forgiveness is not reflected in this table, as carriers contributed to the fund in 2009 and 2010 but do not forecast contributions in 2011.

Of note are the following observations:

- All three health plans met their 2010 goals. United managed its targets so as to make extra commitments for primary care spend in quarter four of 2010.
- The carriers chose somewhat different priorities for meeting their spend goals. United focused on fee schedule enhancements and one-time payments, whereas BCBSRI had a had more systematic and strategic approach, investing in a patient-centered medical home (PCMH) program.
- The Advisory Council noted that increases to primary care spend under this standard should not be passed on in the form of higher premiums to carriers. There is no specific cost allocation mechanism to verify how this was followed, but rate review by OHIC and price competition in the market are two pressure points to prevent this from happening.
- Projection accuracy is difficult to obtain because of lags in claims payment and shifts in enrollment.
- Advance planning by health insurers will be important as the spending targets for 2011 and subsequent years increase significantly. This is particularly the case for United, which to date has not an explicit multi-year plan for this work.
- Regular monitoring, frequent dialogue to address issues, and public accountability to OHIC is also important if health insurers are to continue this work. OHIC's early efforts in this work are largely funded through federal monies made available as part of the Affordable Care Act.

Standard Two: All-Payer Patient-Centered Medical Home Project*Monitoring Methods*

This standard assesses plan performance by measuring ongoing participation in the Chronic Care Sustainability Initiative (CSI). Financial support of the CSI project by insurers applies to the primary care spend standard as well.

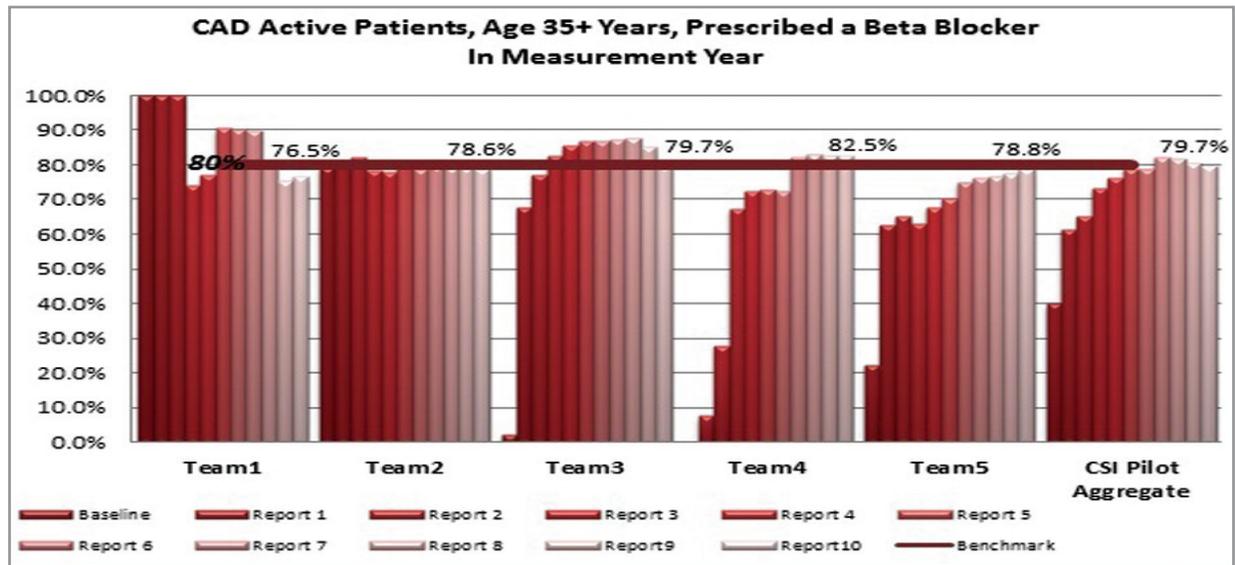
Assessment of Compliance

All three commercial insurers continue to participate in the project. Total financial investment annually by the insurers (including provider payments) for 2010 was \$1,755,316, allocated proportionately to insurers' enrollment in the project.

Now over five years old, with 60 primary care providers in 13 different settings participating, the CSI project enjoys widespread support in the medical community. Of note are its collaborative multi-stakeholder governance model, its common contracting terms, now in their second iteration, its results in improved care quality and provider satisfaction, and its alignment with other community initiatives focused on improving the quality and capacity of primary care to manage patients with chronic conditions. In the fourth quarter of 2011, Medicare will commence

its participation in this project as a payer – one of eight projects it has selected to participate in nationally. Medicare’s involvement in this project will help bring in important additional funds for the participating primary care practices.¹² An example of improved clinical quality performance in CSI participating sites is shown in the figure 8 below.

Figure 8: CSI Quality Improvement Results



Standard Three: Electronic Health Record (EHR) Incentives

Monitoring Methods

Health plans must attest to OHIC on the existence of EHR incentives and the availability of these incentives to providers.

Assessment of Compliance

All plans attest to the availability of these EHR incentives. OHIC does not regularly monitor any aspect of their administration. Attempts to coordinate the administration and nature of the EHR incentives from the private insurers through the Rhode Island Quality Institute (RIQI) have not been successful.

Given other OHIC priorities, the existence and attention paid to Medicare EHR incentives, corresponding “meaningful use” standards, and economic stimulus grants awarded to the RIQI for the purposes of preparing providers to adopt EHRs, this Affordability Standard may be the one most ripe for review by HIAC. However, insurer participation has not been questioned.

Standard Four: Hospital Payment Reform/Hospital Contracting Conditions

Monitoring Methods

Unlike standards one and two, OHIC does not actively work with the health insurers on the implementation of this standard. Instead, OHIC instructed health insurers to give signed attestations as new contracts were executed that the contract complied with conditions. In addition, OHIC required attestations and contract language be submitted in May 2011 as part its annual rate review.

¹²See www.pcmhri.org for more information on the CSI project.

Assessment of Compliance:

1. Process:

OHIC notes that all three health insurers only sent in attestations when directly asked for a specific contract – either at the time of contract completion or on the occasion of the Rate Factor Review. Health plans have verified the information below. OHIC has not conducted independent reviews of the contracts in question.

Health Insurers were reluctant to submit full contract language as part of the attestation, in spite of condition six. In all cases they only agreed to when given permission to submit redacted version as part of their publicly accessible documents. OHIC believes its access to contractual information is not at question, but how that information is summarized for public use is an ongoing conversation. Traditionally, insurers and hospitals alike have viewed this information as proprietary and confidential, even as many parties have expressed concern about the fairness of those negotiations.¹³ OHIC believes there is a strong public interest in holding insurers and providers accountable for their business arrangements – particularly in the case of hospitals, where Medicaid and Medicare determine fifty percent of their revenues in a very public (if complex) fashion. Until further statutory or regulatory clarification is provided OHIC will continue to collect and make contractual information available in ways which improve public accountability but do not, in its judgment, impose economic disadvantage to any party. OHIC will continue to consult with the insurers as it develops these policies.¹⁴

2. Information on Conditions: The following table summarizes relevant contractual language sections as presented to OHIC.¹⁵

Figure 9

| Carrier | Hospital and contract period | Condition 1: Units of Service | Condition 2: Rate of Increase | Condition 3: Quality Incentives | Condition 4: Administrative Simplification | Condition 5: Care Coordination | Condition 6: Transparency |
|---------|--------------------------------|---|-------------------------------|---|--|---|---------------------------|
| BCBSRI | Hospital One (one year) | Convert to payment based on DRG's by 10/11; APC's 12/11 | Medicare CPI | Incentives to be determined with value up to x% | Formal discussions to identify opportunities | A process to evaluate, identify and implement efforts | Yes |
| BCBSRI | Hospital Two (one year) | Global payments modeled Reconcile to DRG/APC's by 7/11 | Medicare CPI | Incentives to be determined with value up to x% | Formal discussions to identify opportunities Joint operating committee established to focus on "performance of agreement" | A process to evaluate, identify and implement efforts Joint operating committee established to focus on "performance of agreement" | Yes |

¹³Rhode Island statutes, R.I. Gen. Laws chapter 6-41, offer clear guidance concerning what information is protected as a "trade secret" in connection with disputes between private parties. However, the trade secrets statute, when read together with the Access to Public Records law (R.I. Gen. Laws chapter 38-2), only permits a public agency to decline to release proprietary information. The Access to Public Records Act does not require an agency to maintain the confidentiality of proprietary information. *Rhode Island Federation of Teachers v. Sundlin*, 595 A2d 799 (1991). See also *In re New England Gas Company*, 842 A2d 545 (2004).

¹⁴Carriers may request protection of proprietary information in documents filed with OHIC, including contract details. To assist OHIC in applying the legal principles cited here, the carrier's request must be accompanied by supporting factual and legal analysis with respect to (a) whether the specific information for which confidential treatment is requested satisfies the statutory criteria of a "trade secret" under R.I.G.L. 6-41-1, or the criteria of any other statute upon which the request for confidential treatment is based; and (b) whether the interests of the carrier in maintaining the confidentiality of the information outweighs the interests of the public in a transparent rate review process. See R.I.G.L. 42-62-13(a).

¹⁵Details have been omitted based on OHIC interpretation of protected trade secrets.

| Carrier | Hospital and contract period | Condition 1: Units of Service | Condition 2: Rate of Increase | Condition 3: Quality Incentives | Condition 4: Administrative Simplification | Condition 5: Care Coordination | Condition 6: Transparency |
|---------|------------------------------------|---|---|--|--|--|---------------------------|
| Tufts | Hospital One | Per Diems and CPT codes – transition to Case Rates based on membership growth | With consistent utilization, 4.4% increase for IP and 1.5 % for OP, for aggregate of 2.1% | Incentives to be determined with value up to x% | Assignment of contract specialist by Tufts | Agreement to formalize communication during the year | Yes |
| United | Care New England (three hospitals) | In December 2010, as part of a multipart lawsuit, CNE sued OHIC regarding the enforceability of the hospital contracting conditions. OHIC subsequently granted United a waiver from the conditions for the CNE contract only. United subsequently signed a contract with CNE and did not provide information on its contents to OHIC at the time of the rate factor review process. | | | | | |
| United | Hospital One (two years) | Convert to payment based on DRG's by 11/11. Already materially equivalent to APC's | Medicare CPI plus "market discrepancy" adjustment in 2011. | Incentives to be determined with value up to x%. For May 2012, value of y% | Joint operating committee established to discuss pertinent matters | Specific communication expectations of hospital to pcp. | Yes |
| United | Hospital Two (two years) | Convert to payment based on DRG's by 10/11. Already materially equivalent to APC's | Medicare CPI | Incentives to be determined with value up to x% for 2010. | Focus on claims payment and submission error reduction. | Hospital attests to establish processes in place. Agree to document process. | Yes |
| United | Hospital Three (one year) | DRG payment methods in place. Already materially equivalent to APCs. | Medicare CPI | Incentives to be determined with value up to x% | Not explicitly negotiated. System of biweekly calls in place | No specific terms were negotiated | Yes |

1. *General Compliance*

Health insurers' attempts to comply with this standard are documented but are not nearly as clear and consistent as with the first three standards.

This is likely due to several factors:

- a. Specific guidance from OHIC was more difficult. The conditions that comprise this standard are administratively more complex and less objectively measurable than standards one and two particularly. In particular, information is lacking on the nature of quality incentives agreed to. It may be desirable to have more consistency in these measures across insurers and hospitals. OHIC is conducting a separate report examining this issue.
Health plans also administer quality incentives differently. In some cases incentives are paid as lump sums retrospectively, in other cases they are paid along with base rate increases – either in subsequent years or prospectively with a subsequent readjustment. The second and third options were not OHIC’s intent in developing the condition. The effect of incorporating incentive payments completely into base rates – which could result from this practice - is to raise future hospital prices beyond the price trend and is not the intent of the hospital conditions language .
- b. Compliance depends significantly on the efforts of another party – the hospital – not subject to OHIC’s authority or the insurer’s management control. This was particularly the case with Care New England’s stance with United Health Care. Health insurers in communications with OHIC at the time of the promulgation of the conditions clearly foresaw this possibility and each expressed their concerns to OHIC. For now, the consequences of non-compliance for hospitals remain public accountability for their efforts to improve system affordability. This has been clearly less of a concern for some hospitals such as CNE than for others.
- c. Monitoring was not concurrent. Unlike the first three standards, OHIC did not work with the health insurers in a structured way to obtain regular updates of contracting discussions. Staff resource limitations, past practices, and the duration and complexity of contract negotiations all contributed to this.

Quality Incentive Payments: Size

This report does not disclose the size of the percentage payment for attainment of quality incentives negotiated by insurers and hospitals. Carriers expressed concerns that specific payout identification could lead to a “rising tide” phenomenon. OHIC notes that in all cases the maximum pay out was at least two percent, as its conditions required, so health plans were compliant. Actual amounts ranged from two to five percent and there was no apparent correlation between the amount negotiated and the insurer or hospital size. It should be noted these amounts are maximum payouts if all performance standards were met. OHIC did not collect information for this study on the standards used so no assessment can be made about probable payments to hospitals under these terms.

2. *Assessments of Specific Insurer Compliance*

Given the observations of section 1, the standards for assessing compliance of insurers with condition four will be initially weighted towards “good faith efforts”. In subsequent years, with clearer and consistent expectations, insurers should expect higher standards.

Blue Cross Compliance:

- a. Conditions one, two and six appear to be satisfied in all cases
- b. Conditions three, four and five are also met. “Agreements to agree” – as was reported for both contracts for conditions three, four and five – was not the intent of those conditions, but OHIC acknowledges the original language was subject to interpretation. The difficulties of fully negotiating these issues prior to contract signing are also noted. BCBSRI has also provided evidence that subsequent negotiations resulted in agreements that met condition three. Additional language put forth by OHIC in 2012 addressed these issues.

Quality Incentive Payments: How should they be administered?

OHIC noted significant variation in how the Quality Incentive Payments were implemented in various contracts. While the third condition is clear that payments under such incentive programs were not to become part of the base rates for subsequent years, in some cases payments were made in the first year under the assumption of full compliance. Contractual arrangements were made in these cases to recoup any incentives not fully earned in the subsequent year. However subsequent years would also be adjusted by incentive payments in those years. This will make for complicated accounting at best and possible inclusion of incentives in the base on which future increases are calculated.

Some of this variation is due to the outcome of private negotiations, and some of this was due to a strong desire on the part of some carriers to avoid lump some payments outside the claims system, which can be very problematic for assessing self insured employers. The results however can be confusing to administer and inconsistent.

While it is understood by all involved that incentive payments are not to be incorporated into base rates to hospitals in current or future years, it is an open question how explicit OHIC should be in its directions for these payments. Too much prescriptiveness may encourage an excessive focus on compliance and discourage the kind of payment reform and innovation which was intended. Incentive payments are a small portion of total payments, and affordability efforts need to be focused on identifying and eliminated unneeded utilization. This should be the focus health plan and hospital contracting efforts.

United Compliance

- a. Conditions one and six appear to be satisfied in all cases.
- b. Condition two was met in two cases and not met in the third. OHIC acknowledges that such an adjustment beyond Medicare CPI may be merited for hospital-specific reasons, but United did not address this non-compliance issue with OHIC either before or after the negotiations.
- c. Condition three was met. Again, as with BCBSRI, “an agreement to agree” was not the intent of the condition, but it could have been interpreted in this fashion.
- d. Both conditions four and five are met in one case, partially met in a second and not met in a third.

Tufts Compliance

- a. Condition two and six appear to be satisfied in all cases.
- b. Condition one is not fully met. OHIC is sympathetic to the argument that more volume is necessary but no expectations were set neither in contract nor with OHIC.
- c. Conditions three four and five were met but with the caveats cited for BCBSRI in 2.b.

Policy Assessment of Effects of Affordability Standard Four

This document is primarily a compliance assessment; however the utility of this Affordability Standards will be briefly reviewed as well.

Based on this table and a comparison with the baseline documented in 2010, it appears health plan contracting processes with hospitals clearly changed with the issuance of the contracting conditions in the following ways:

- Units of service were moved from per diems to efficiency-based services.
- Price increases were limited. OHIC expects to see this reflected in future rate filings.
- The use of quality incentives was increased.

- Some collaborative administrative efforts to improve efficiency and care coordination were initiated.
- Transparency and accountability for contracting activity were significantly increased.

Numerous policy questions are suggested. Are these the right contracting conditions and the appropriate degree of specificity? What is process for reviewing and revising these conditions? How are stakeholder concerns to be addressed – including hospital accountability, variations in payment levels among payers and by hospitals, and the stated need for statewide planning efforts? Unless the Legislative Branch addresses these questions more directly, consistent with its statutory direction OHIC will work with commercial insurers and community stakeholders on provider contracting methods to improve health insurance affordability. It will also work with other agencies in the Executive Branch and community stakeholders to address the more systemic questions raised by the implementation of Affordability Standard Four.

The affordability of Rhode Island’s commercial health insurance will continue to be influenced in part by the actions of Rhode Island hospitals. Although not directly regulated under OHIC’s statute, hospitals in turn are clearly influenced by the actions of health insurers and the actions of OHIC – which is charged with ensuring the fair treatment of providers. Given their status as large community assets with significant local, state-wide and community roles, OHIC believes it critical policy makers work with hospitals in policy discussions regarding how medical care systems in Rhode Island can best be organized and paid to meet the needs of all Rhode Islanders. An essential part of these discussions will be how health insurers contract with hospitals in the future. Consistent with statutory direction, OHIC is committed to engaging hospitals individually and collectively in publicly accountable processes in this work. Several opportunities for innovative payments to hospitals are proposed under the Affordable Care – some of these will be mandated (incentives related to hospital acquired infections and readmissions) and some are optional (Accountable Care Organizations and bundled payments). These may present opportunities for multi-payer commercial alignment as well.

Refining Affordability Standard Four

As a result of the analysis of compliance with Affordability Standard Four, OHIC has or will take several steps:

1. It incorporated the original hospital contracting conditions (as well the other three Affordability Standards) in a proposed re-drafting of its regulation two (“Affordability Regulation”). This is currently still in draft form and has not been adopted.
2. It redrafted the conditions in conjunction with the May 2011 Rate Factor filing, adopting slightly modified versions of conditions three, four and five to create more reporting and accountability.
3. It is conducting a separate study on the nature of quality incentives employed in hospital/health plan contracts as a result of Affordability Standard Four to assess the appropriate levels of consistency across hospitals and carriers.
4. It promulgated those draft conditions prior to the completion of the rate factor review to allow for public comment.
5. In connection with the 2011 Rate Review process, when carriers ultimately filed rates which were approved by the Commissioner, carriers also filed a Waiver and Consent to the hospital contracting provisions established in Affordability Standard No. 4. As a result, each carrier’s legal obligation to comply with Affordability Standard No. 4 is consistent and clear.
6. It will commit additional resources to the process of setting guidance regarding the conditions and monitoring insurer compliance with them.
7. In particular, it will draft guidance – to supplement the regulatory process - to the health insurers for each of these conditions, especially with regard to the practice of paying for performance on quality incentives as part of the base price increase.

8. OHIC will consider insurer-specific enforcement to address any material non-compliance with Affordability Standard No. 4.¹⁶

Evaluation of Efficacy of Affordability Standards

In its initial report, the HIAC set out the following measures for evaluating the effectiveness of the Affordability Standards. The measures themselves were selected as sentinel indicators – many others could also be investigated. Although the topic of this report is assessing health insurer compliance with the standards, the status of the measures will be briefly addressed here:

1. **Lessening of health insurance premium trends:** As is evidenced by this report, this has not been accomplished. However, this lack of impact was expected at this stage of implementation.
2. **Effects on ambulatory care sensitive ER visits and inpatient readmissions:** The State of Rhode Island has not yet been able to assemble baseline measures for the state as a whole or by relevant sub populations (by primary care provider group, by payer source, etc.). Statutory authority to do this work exists and progress is being made through the efforts of several partners in and out of state government. Although the availability of federal funds to support the work has helped this process, competing priorities have hindered its progress.
3. **Number of PCPs per capita and primary care provider satisfaction:** No baseline measures are available here. Only limited efforts are being made to collect them.

This report notes that for these evaluation measures to be effective, their use must be more broadly adopted and supported beyond the commercial insurance sector and across state agencies, since the medical care system in RI comprises more than just commercial insurance.

Summary

This report analyzed the compliance of health insurers with the Affordability Standards promulgated by OHIC in 2009 and modified by the Hospital Contracting Conditions in that same year. Conclusions include the following:

1. The Office acknowledges the commitment and collaboration demonstrated by Rhode Island's commercial health insurers in performing the work outlined here, much of which is groundbreaking in its scope and nature.
2. Insurers are compliant with Standards 1 and 2. These have been marked by intense health insurer collaboration with OHIC and other partners, objective standards, regular monitoring by OHIC, and public accountability.
3. Insurers appear to be compliant with Standard 3. OHIC monitoring of this standard has not been as focused. Its continuation should be assessed.
4. Insurers' compliance with Standard 4 varies by insurer but is less complete in general, for reasons both inside and outside of insurer control. While OHIC will make necessary adjustments and enforcement actions, the lessons of Standards 1 and 2 - monitoring, public accountability, and objective standards - should be applied here.
5. OHIC will work with health insurers to make these changes and continue to implement payment reform. Medicare changes under the Affordable Care Act could be useful benchmarks. However, appropriate public policies for hospital contracting and provider payment reform to improve medical care affordability will extend beyond the realm of commercial insurance and the OHIC statute. The commercial insurance sector's experiences with implementing this Affordability Standard will prove useful for this process.

¹⁶OHIC understands that failure to comply may arise from circumstances beyond the carrier's control; for example, the refusal of a Rhode Island hospital to agree with one or more required contractual terms. In those or similar circumstances the Commissioner will determine what consequences, if any, should be imposed on the carrier, after providing the carrier with an opportunity to demonstrate that it has been unable to comply, notwithstanding the good faith, diligent and rigorous efforts of the carrier, and after consideration of all other relevant circumstances including impacts on policyholders. In the absence of a sufficient demonstration of good faith, diligent and rigorous efforts of the carrier, however, carriers will be held accountable for any resulting harm to the interests of the public. R.I.Gen. Laws 42-14-16.

6. A significant priority needs to be placed on measuring and reporting system performance. The lack of these measures and monitoring, done systematically for Rhode Island, hinders the work that is described here.
7. Finally and most significantly, this assessment indicates that it is indeed possible to set public priorities for insurer efforts to improve system affordability, monitor their progress and hold them accountable for this important work. This is an ongoing process, which should be marked not only by consistency but also by evolution. More work remains to be done on finding the right balance between specificity and flexibility in guidance to insurers, providing resources and focus for monitoring and evaluation efforts, and achieving consistency in public policies for those areas outside the authority of the Office and the management control of insurers.