OFFICE OF THE
HEALTH INSURANCE COMMISSIONER

STATE OF RHODE ISLAND

Blue Cross & Blue Shield of Rhode Island

Report on Hospital Participation Agreements with the

Care New England Health System

TO

The State of Rhode Island

Office of Health Insurance Commissioner

Final Recommendation and Examiner Verification

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RECOMMENDATIONS OF EXAMINERS AND VERIFICATION

Based on the foregoing report of Rector & Associates, Inc., as well as our review of the CNE Agreements and examination workpapers, we recommend that the Commissioner adopt in full the report, taking into consideration the following conclusions and recommendations we find reasonably warranted from the report, workpapers, and CNE Agreements:

1. Blue Cross's legal authority to enter into the Cost Shifting provision is highly questionable. The financial arrangement created by the Cost Shifting provision possesses many insurance-like qualities. Under the Cost Shifting provision of each hospital's contract, Blue Cross is obligated to indemnify the entire Care New England system (this means all the CNE hospitals and affiliates not just the particular contracting hospital) for reductions in net patient revenue or increases in expenses due to future, unknown actions that may be taken by the state and federal governments related to health care programs such as Medicare and Medicaid. Under the contracts, the indemnification payments are to be made through increases to base rates according to a tiered schedule. In essence, CNE, as the indemnitee, will be paid a sum by Blue Cross, as the indemnitor, by way of compensation for a particular, specified, contingent loss that could be suffered by CNE. Such payments will be made based on future occurrences of specific, fortuitous events over which Blue Cross and CNE have no control and the occurrence of which triggers payment. The risk that CNE will suffer such reductions in net patient revenue or increases in expenses because of government action is assumed by Blue Cross for consideration—the provision is part and parcel of a complex agreement between Blue Cross and CNE whereby CNE provides access and services to Blue Cross subscribers and Blue Cross provides payments—and that risk would then spread among Blue Cross subscribers by way of potentially larger rate increases. Indeed, there can be little doubt that the overall objective of this arrangement is to shift risk from CNE to Blue Cross for valuable consideration (i.e., continued in-network access to the CNE hospitals by Blue Cross members). Furthermore, Blue Cross accepted this risk as a business decision, just as it accepts the risk of any other group it insures.

2. As a result, there is:

    a. A contract;

    b. containing a provision for indemnification of one party by another;

    c. with indemnification payments triggered by the future occurrence of specific, chance events over which the parties have no control;

d. with the risk of payment assumed by one party, which is then spread among a large group (the Blue Cross subscribers);

e. in exchange for consideration;

f. undertaken based on a business decision to accept such risk; and

g. with the overall objective of insuring against that risk.

3. In light of such facts, it is difficult to see the Cost Shifting provision as something other than a contract provision that creates an insurance obligation on Blue Cross.[1]

4. Given that Blue Cross is a creation of statute and is only authorized to write lines of insurance with respect to certain types of risk, specifically (1) health insurance;[2] (2) stop-loss and catastrophic insurance;[3] and (3) the types of insurance that may be provided by nonprofit dental service

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[1] This is confirmed in a June 1, 2010 Blue Cross letter to CNE related to the Cost Shifting provision which states: "As both parties will recall, the intent of the . . . [Cost Shifting] provision in the CNE agreements is to afford protection to the provider for significant changes in state or federal regulations that impact CNE's revenue, regulatory changes that were not anticipated during the negotiation of this new contract."

[2] R.I. Gen. Laws § 27-19-1(3) (defining a nonprofit hospital service plan as "a plan by which specified hospital care is to be provided to subscribers to the plan by a contracting hospital"), § 27-19-5(a) (allowing nonprofit hospital service corporations to contract for hospital services to be rendered to subscribers), § 27-20-1(6) (defining a nonprofit medical service plan as "a plan by which specified medical service is provided to subscribers to the plan by a nonprofit medical service corporation"), § 27-20-1(4) (defining medical services as "professional services rendered by persons duly licensed under the laws of this state to practice medicine, surgery, chiropractic, podiatry, and other professional services rendered by a licensed midwife, certified registered nurse practitioners, and psychiatric and mental health nurse clinical specialists, and appliances, drugs, medicines, supplies, and nursing care necessary in connection with the services, or the expense indemnity for the services, appliances, drugs, medicines, supplies, and care, as may be specified in any nonprofit medical service plan" but not including hospital services), § 27-20-5 (allowing nonprofit medical service corporation to contract for medical services to be rendered to subscribers), § 27-19.2-3 (noting that one of the purposes of nonprofit hospital and/or medical service corporations is to "provide affordable and accessible health insurance to insureds"). While the General Assembly has authorized a subsidiary of Blue Cross to develop, underwrite and offer for sale other health-related lines ("life insurance, disability insurance, long-term care insurance, employee assistance programs and/or other health related programs") subject to the prior approval of the health insurance commissioner, Blue Cross itself is expressly prohibited from underwriting such lines. Blue Cross may, however, offer such products for sale. R.I. Gen. Laws § 27-19-5.3.

[3] R.I. Gen. Laws § 27-19-5(d). Blue Cross may, however, only write stop-loss and catastrophic insurance for fully and partially self-insured health benefit plans sponsored by employers, associations, and third parties, R.I. Gen. Laws §27-19-5(a)(4), and is required to file the rates for such products with OHIC and obtain approval before such products are offered in the market. R.I. Gen. Laws § 27-19-5(d).

corporations, nonprofit legal service corporations, and nonprofit optometric service corporations,[4] and is not authorized to write any other lines of insurance, it is difficult to see how Blue Cross's obligations under the Cost Shifting provision do not exceed Blue Cross's statutory authority. Indeed, OHIC certainly would not have allowed Blue Cross to enter into a stand-alone contract of insurance whereby Blue Cross agreed to indemnify CNE (or anyone else) for some or all of its losses on government programs in exchange for a premium. Had Blue Cross approached OHIC for permission to undertake the exact same obligations set out in the Cost Shifting provision in exchange for a monetary premium, OHIC would have denied the request on the ground that the arrangement would have exceeded Blue Cross's authority. Had Blue Cross undertaken the exact same obligations set out in the Cost Shifting provision in exchange for a monetary premium without seeking prior OHIC approval, OHIC would have ordered Blue Cross to cease providing the illegal insurance product and would likely have issued an administrative penalty against Blue Cross. OHIC should not, therefore, allow Blue Cross to undertake the very same insurance obligation simply because it is embedded in another, larger and more wide-ranging set of agreements in which access and services provided by the CNE hospitals substitute for a monetary premium.

5. Our conclusion is supported by the fact that the Cost Shifting provision is not simply a mechanism that accounts for increases in medical costs incurred by the CNE hospitals as a result of its participation in government programs and then passes those costs along to Blue Cross because recovery of such costs are necessary to provide services to Blue Cross's subscribers.[5] Instead, the Cost Shifting provision appears to be designed to ensure that streams of net income derived separately from Medicare and Medicaid are (at least partially) guaranteed by Blue Cross.[6] The manner by which the Cost Shifting provision operates makes this apparent. For the purposes of calculating what Blue Cross will pay under the Cost Shifting provision, three separate calculations are made each year, one each for "Medicaid," "Medicare," and "other state/federal actions." In each calculation, so-called "positive events," (i.e., events that increase revenues to CNE or lower CNE's costs) will be offset against "adverse events" (i.e., events that decrease revenues to CNE or increase CNE's costs) to produce a net dollar figure for each calculation. If any of the three calculations produces a positive number,

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[4] R.I. Gen. Laws § 27-19-5(b). This means dental coverage, R.I. Gen. Laws § 27-20.1-1 (1)-(3), optometric coverage, R.I. Gen. Laws § 27-20.2-1 (1)-(3), and coverage for legal services, R.I. Gen. Laws § 27-20.3-1 (1)-(3).

[5] This statement is not intended to suggest that the Examiners believe that a contract mechanism that merely passed alleged losses on state and federal programs to Blue Cross for payment is appropriate. It is included to address the issue of what the Cost Shifting provision actually does.

[6] See footnote 7.

it will not be used further in determining a change to the base rates Blue Cross will have to pay to CNE. If, however, a calculation produces a negative dollar figure, the negative dollar figure will be used to increase the base rates payable to CNE by Blue Cross. Under this methodology, it becomes clear that the Cost Shifting provision is not configured to strictly reimburse CNE for any alleged losses it may suffer as a result of its participation in government programs. If that were the case, the three calculations would be netted-out. They are not. Instead, the following scenario is possible: (1) the "Medicare" calculation is $1 million because of "positive events", (2) the "other state/federal action" calculation is $1 million because of "positive events", and (3) the "Medicaid" calculation is -$2 million because of negative events. Under such a scenario, CNE would suffer a net $0 impact from government actions and CNE would, on the whole, be no worse off than if each calculation separately netted to $0. Furthermore, under this scenario the net effect of CNE's participation in government programs on CNE's ability to provide services to Blue Cross subscribers would also net to $0. Yet, under this scenario, because the "Medicare" and "other state/federal actions" calculations each resulted in a positive number, they would be disregarded for the purposes of calculating Blue Cross's increased base rate payments. Only the negative "Medicaid" calculation would be used, thereby resulting in additional payments to CNE by Blue Cross.[7] Thus, if net Medicare income goes up and net Medicaid revenues go down, Blue Cross still has to make payments to CNE to at least partially replace lost Medicaid revenues, regardless of the overall net effect of government programs on CNE revenues.

7. Further support for our conclusion lies in the fact that the Cost Shifting provision, which states that the "Medicare," "Medicaid," and "other state/federal" calculations are based on "(i) Federal and/or State actions which directly reduce the net patient revenues collectively of CNE . . . ands its affiliates . . . or (ii) Federal and/or State actions which directly increase expenses to [CNE ands its affiliates]," explicitly says that no more than $5 million of increased expenses shall be included in the calculation in any given year. Yet, there is no similar cap on events that reduce net patient revenue.[8] Again, this suggests that the point of the

[7] Under such a scenario, Blue Cross's additional payments to CNE would be about [redacted] since, under the tiered payment methodology of the Cost Shifting provision the first $1 million would not be counted, and the second $1 million would be assessed on a pro-rata basis according to Blue Cross's share of CNE's reimbursements.

[8] The events that increase costs or reduce revenues are not defined and are thus sufficiently broad so as to encompass every possible government action that could have an effect on CNE's costs or revenues. Again, this suggests that the point of the Cost Shifting provision is less about recovering lost costs and more about ensuring streams of income from Medicare and Medicaid. This is demonstrated in the first statement sent to Blue Cross from CNE related to the Cost Shifting provision. One of the calculations included in that statement resulted from a reduction of

Cost Shifting provision is less about recovering lost costs and more about ensuring that streams of income derived separately from Medicare and Medicaid are (at least partially)[9] guaranteed.

8. In addition to the fact that the Cost Shifting provision creates an illegal insurance obligation on Blue Cross, the open-ended nature of the Cost Shifting provision places Blue Cross's reserves at risk and could potentially jeopardize Blue Cross's solvency. As noted in the report, under a "worst case scenario," the Cost Shifting provision could increase the amount payable to CNE by Blue Cross by many millions of dollars on very short notice (and possibly before Blue Cross could recover those amounts through rate increases). In addition, Blue Cross has potentially ceded ultimate control over the rates it pays CNE, and therefore potentially placed its solvency in the hands of an unknown third party—a mediator. Under certain circumstances the Cost Shifting provision allows the CNE Agreements to be reopened, with Blue Cross's liability under the Cost Shifting provision subject to binding mediation. As noted in the report, there is nothing in the CNE Agreements that establishes an "outside limit" to Blue Cross's potential liability and there is no "escape clause" Blue Cross could invoke in the event the increased payments to CNE would cause financial harm to Blue Cross. While the report and the examiners acknowledge that such a catastrophic scenario is unlikely, it is nevertheless possible and Blue Cross has, by contract, agreed to submit itself to such potentially catastrophic consequences. There is no doubt that this level of risk is inconsistent with Blue Cross's statutory mandates, especially its mandate that it protect its financial condition (R.I. Gen. Laws § 27-19.2-10(4)).[10]

Rite Care eligibility for those categories of eligible persons who have incomes between 250% and 350% of the federal poverty level ("FPL"). This reduction of eligibility above 250% FPL was a programmatic change implemented by the State of Rhode Island in order to reduce its Medicaid costs. In other words, the state determined that a class of persons for whom it had previously provided Medicaid coverage would no longer be eligible for that coverage. How those persons previously covered would thereafter pay for their medical care is unclear. They likely would either have to buy commercial health insurance or go without health insurance. Nevertheless, CNE took the position that the stream of income that had previously been provided via the state's Medicaid program for these formerly eligible persons would have to be provided by Blue Cross instead. Ultimately, Blue Cross challenged the inclusion of this item in the Cost Shifting calculation, but not on the ground that it was not contemplated by the Cost Shifting provision. Instead, Blue Cross argued that CNE did not fully support the dollar figure for the item with documentation. CNE ultimately withdrew the inclusion of that item, ostensibly for the documentation reason.

[9] See footnote 7.

[10] It also appears that Blue Cross may have explicitly exceeded its statutory authority by contracting to provide payments to CNE that are not related to services provided to patients. Pursuant to R.I. Gen. Laws § 27-19-5, entitled, "Contracts with subscribers, hospitals, and other eligible entities," Blue Cross is given the explicit authority to contract with "any eligible hospital for hospital service to be rendered by the contracting hospital to the subscribers and as to the

9. Given that the Commissioner is required to discharge the powers of the Office to "[g]uard the solvency of health insurers" (R.I. Gen. Laws § 42-14.5-2(1)) and enforce the provisions of Title 27 of the General Laws, it is therefore our recommendation that the Commissioner order Blue Cross not to make any payments arising under the Cost Shifting provision and, in lieu thereof, to use its best efforts to renegotiate the CNE Agreements in a manner consistent with its legal authority. This would preclude from the renegotiated contracts any cost shifting component and any provision in which Blue Cross cedes authority over the reimbursement rates it pays to a provider to a third party. We also recommend that the Commissioner consider whether, in light of the insurance-like nature of the Cost Shifting provision and its potentially disastrous impact on Blue Cross's solvency and/or the rates charged to subscribers, an administrative penalty against Blue Cross is appropriate.

The examiners hereby verify under oath pursuant to R.I. Gen. Laws § 27-13.1-5(b) that the foregoing written report of the examination and recommendations are the true and correct written report of the examination and recommendations issued pursuant to the examination warrant issued to Blue Cross and Blue Shield of Rhode Island on February 9, 2009.

Joseph Torti, III
Deputy Director and
Superintendent of Insurance
Department of Business Regulation
Examiner

John Aloysius Cogan Jr.
Examiner

Dated: October 22, 2010.

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nature and extent of those services." Blue Cross is not given further authority to provide revenue guaranties or insurance to a hospital and is not given the authority to contract with a hospital to make payments beyond those required for the "service[s] to be rendered by the contracting hospital to the subscribers and as to the nature and extent of those services." R.I. Gen. Laws § 27-19-5(a). There is no question that the payments contemplated by the Cost Shifting provision are wholly and completely unrelated to services to be rendered by CNE to Blue Cross subscribers.