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Issue Brief

Using Insurance Standards and Policy Levers to Build a High Performance Health System

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ABSTRACT: This issue brief examines an unprecedented use of state health insurance regulatory authority to promote health system reform. In 2004, the Rhode Island legislature created the Office of the Health Insurance Commissioner (OHIC) with authority not granted to state health insurance regulatory agencies in other states. Specifically, the legislation instructed OHIC to direct insurers toward policies that promote improved accessibility, quality, and affordability for the Rhode Island health system. In 2009, OHIC used this authority to implement a set of standards to promote increased affordability through a series of requirements aimed at strengthening and expanding the state's primary care infrastructure. Insurers are required to increase their investments in primary care on a cost-neutral basis, expand use of the chronic care model medical home, and support implementation of electronic medical records. Rhode Island is testing whether state insurance regulation can foster a profound transformation in health care delivery.

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Overview

States have been regulating private health insurance companies and products since the late 19th century.[1] Regulations typically address insurer solvency and consumer protections relative to marketing, coverage policy, claims payment, access, and quality assurance. The advent of managed care created a flurry of state regulatory activity between 1992 and 2002, fueled by consumer and provider concerns about the potentially deleterious effects of managed care on both patients and providers. There has been dramatically less new health insurance regulatory activity in states since that time.[2]

All of this state regulatory activity has not, however, addressed insurer obligations regarding the systemic issues of medical care affordability and cost containment. This issue brief describes Rhode Island's innovative and unprecedented use of health insurance statutes and regulations to promote system reform

by addressing the need for expanded primary care capacity and transformative changes to primary care delivery.

Health Insurance Regulation in Rhode Island

Rhode Island is the geographically smallest state in the United States and has a population of approximately 1 million. The commercial insurance market is largely divided between two insurers, Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England. The two insurers possess approximately 70 percent and 30 percent of the fully insured commercial health insurance market, respectively. A third commercial insurer, Massachusetts-based Tufts Health Plan, entered the market in the spring of 2009.

In previous years, and in accordance with its statutory authority, the state's department of business regulation performed occasional reviews of the factors health insurers consider when calculating proposed premiums for fully insured Rhode Island employers. Informed by the results of the analysis, the department could approve, reject, or modify the proposed rate factors.

The department evaluated whether the proposed rate factors were "consistent with the public interest and the proper conduct of business"[3] based on two key standards:

- **Solvency and actuarial soundness.** Were the proposed rates sufficient to ensure the continued solvency of the health plan?
- **Consumer protection.** Would consumers receive adequate contractual benefit in return for the proposed rates?

In 2004, the Rhode Island legislature created the Office of the Health Insurance Commissioner (OHIC) to hold health insurers accountable for fair treatment of providers and to direct insurers toward policies that promote improved accessibility, quality, and affordability.[4]

The explicit statutory direction for "affordability" distinguished Rhode Island from other states. It also gave OHIC the ability to exert influence beyond the normal confines of state insurance regulation. The legislation, however, provided little guidance for interpreting or assessing these new criteria. The authority was limited to fully insured commercial coverage and therefore excluded self-insured coverage, Medicare, and Medicaid.

In 2007, OHIC substantially revised the rate factor review process. In addition to solvency and actuarial soundness and consumer protection, additional criteria were added to address fair treatment of providers and health plan policies to improve affordability, quality, and accessibility of medical care. In addition, OHIC made its rate factor review more consistent across lines of business and insurers, instituting a comprehensive annual process. Finally, the process was made substantially more transparent, with information on the rate factors disseminated to the public.

In the initial years, OHIC did not systematically address the directive to promote improved affordability. In 2008, OHIC required spring annual insurer rate filings to be accompanied by a description of activities insurers had undertaken to address affordability of coverage.

Process to Develop Affordability Standards

In fall 2008, OHIC began developing formal affordability standards for commercial health insurers. The goal was to identify a small number of systemic affordability priorities and set expectations for health plans. Working with state staff, consultants, and OHIC's health insurance advisory council, the agency pursued an open process to identify and assess potential approaches.[5] OHIC's rationale for affordability standards and for using a public process to develop them was as follows:

- Health plan activities can affect medical cost trends.
- Reasonable alignment among payers is possible and beneficial to achieving systemic goals.

Without alignment, health plan affordability efforts will be limited by the ability and willingness of each health plan to influence change.

- Communities can identify system priorities.
- Public discussion of tradeoffs and priorities is better than private discussion.

The work began with identifying a range of options, placing emphasis on those that:

- were unlikely to be advanced absent some degree of state action;
- were shown in the research literature to have a demonstrable, favorable effect on medical cost trends; and
- could reasonably be considered to be within the scope of a health plan's control.

Ultimately, OHIC grouped options into three categories:

- strategies focused on providers: realigning provider payment incentives and practice, beginning with primary care;
- strategies focused on consumers: changing consumer behavior and reducing use of unnecessary services through information dissemination and benefit design;
- strategies focused on health system infrastructure: upgrading and simplifying administrative and clinical information processing and analysis functions.

Exhibit 1 presents the options proposed to the council. Exhibit 2 presents the supporting rationale for each option.

Exhibit 1. Proposed Options for Health Plan Affordability Priorities

	Option 1: Delivery System Focus	Option 2: User Focus	Option 3: Infrastructure Focus
Description	Focus on payment levers of the insurers to realign incentives for care delivery, beginning with primary care	Focus on insurers' ability to change consumer behavior and reduce unnecessary services through information and benefit design	Use insurer funds and national standards to upgrade and simplify the administrative and clinical information processing and analysis functions in the medical care system
Short-term strategies	Increase primary care spending (with limited ability to pass on costs in premiums) Chronic care model medical home	Select wellness performance standards (e.g., increased smoking cessation counseling) Reduce emergency room visits for ambulatory care–sensitive conditions	Standard incentives to use electronic medical records Standard incentives to use e-prescribing
Long-term strategies	Fundamental payment reform	Evidence-based coverage (i.e., use of medical evidence to inform coverage policy)	Create regional health information organization/ health information exchange

Source: Rhode Island Office of the Health Insurance Commissioner.

Exhibit 2. Supporting Rationale for Proposed Options for Health Plan Affordability Priorities

	Option 1: Delivery System Focus	Option 2: User Focus	Option 3: Infrastructure Focus
Rationale	**Primary care spending** ++ General decline in physicians' choosing primary care residencies.[6] ++ A higher ratio of primary care doctors results in better health outcomes.[7] ++ Increasing share of primary care physicians would result in overall healthcare cost savings.[8] ≈ Increasing primary care payments will stem decline in numbers of primary care physicians, promote shift to primary care-centric model. **Chronic care model medical home** ++ Implementing a chronic care model medical home delivers higher quality care, reduced costs.[9,10,11] **Fundamental payment reform** ++ The current fee-for-service system is inflationary.[12,13] ≈ Alternative payment model should produce cost savings.[14]	**Wellness performance standards (smoking)** ++ Tobacco use, obesity results in higher health care costs.[15,16] ++ Increased smoking cessation counseling will reduce costs.[17] ≈ Less evidence of the value of other wellness-related interventions. **Reduce emergency room visits for ambulatory care–sensitive conditions** ++ Solid evidence of overuse of emergency rooms.[18,19] + A reduction in emergency room use and hospitalizations for ambulatory care–sensitive conditions can be achieved through a combination of health plan-driven strategies.[20] **Evidence-based coverage** ++ Solid evidence of misuse/ overuse of services.[21] ≈ The value of establishing consistent, collaborative, evidence-based health plan coverage is relatively unproven. However, limited applications have demonstrated value.[22,23]	**Standard incentives to use electronic medical records** ++ Solid evidence of the cost-effectiveness of electronic medical records.[24,25] **Standard incentives to use e-prescribing** ++ Adoption of e-prescribing saves money and reduces medical errors.[26,27] **Regional health information organization /health information exchange** ≈ Some evidence that a coordinated regional health information organization/health information exchange increases quality of care.[28]

Note: OHIC conducted a review of the evidence of effectiveness of each strategy, using peer-reviewed literature and other sources. Each strategy was rated in terms of the strength of the supporting evidence: ++ = solid evidence, + = equivocal evidence, ≈ = relatively unproven.
Source: Analysis by Rhode Island Office of the Health Insurance Commissioner (OHIC).

The council eventually recommended the development of standards that focused on the delivery system (Option 1), as well as electronic medical record adoption (an element of Option 3). The final recommended priorities statement, approved by the council, read as follows:

"Health plans will 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 spending 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 costs to premiums.

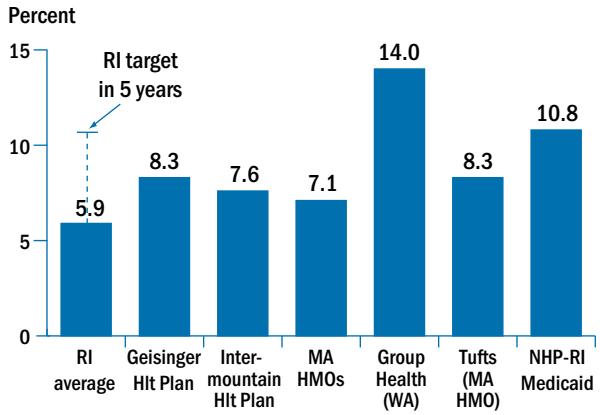
2. Spread adoption of the chronic care model medical home.[29]
3. Standardize electronic medical record (EMR) incentives.
4. Work toward comprehensive payment reform across the delivery system."

Rationale for Rhode Island's Approach

OHIC and the council decided to focus on the delivery system and adoption of EMRs for the following reasons:

- Fee-for-service payment is widely understood to be a major contributor to health care inflation because of its incentive for increased volume of services. The system is unlikely to be replaced by an alternative without government action.
- In 2008, Rhode Island insurers spent 5.9 percent on primary care, which compared poorly against benchmark data from high-performing health systems identified by The Commonwealth Fund's Commission on a High Performance Health System and against other benchmark data (Exhibit 3).
- OHIC and the three commercial insurers had recently collaborated to implement a multipayer chronic care model medical home initiative, which provided a base for expanding primary care payment reform and coupling reform with practice transformation.[30]
- Blue Cross Blue Shield of Rhode Island was offering an incentive to practices to use EMRs; UnitedHealthcare was preparing to introduce such an incentive.
- There was not yet the necessary level of consensus and political support to undertake a larger-scale payment reform initiative.
- Evidence supporting Option 2 strategies (i.e., user focus) was limited and not as compelling as that for Option 1.

Exhibit 3. Benchmarks for Primary Care Expenditures as a Percentage of Total Insurer Medical Spending



Source: Office of the Health Insurance Commissioner (OHIC) analysis.

Process to Develop the Regulatory Standards

OHIC staff and consultants then undertook an effort to develop draft standards, gathering data and input from Rhode Island insurers, advice from an expert panel assembled by The Commonwealth Fund, and data and experience from outside of Rhode Island.[31] The insurers were generally supportive of the areas selected for focus in the affordability standards, and provided constructive, informative data, feedback, and recommendations during the development process.

The expert panel was likewise supportive, but voiced caution about focusing on increased primary care spending without also ensuring improvements in practice performance. They urged attention to the development of clinical microsystems within primary care practices. These are specific processes used by interdependent teams that collaborate on care for patients. Examples include appointment scheduling or follow-up with patients who are not refilling chronic care medications. They also recommended clinical management of high-need patients to reduce hospital admissions and readmissions and advocated the use of metrics focused on clinical outcomes to assess impact.

The council reviewed multiple rounds of standards during the development process and solicited and obtained public testimony at one of its meetings.

Final Approved Affordability Standards

The final standards are summarized below. Complete standards are available at: http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/2_System%20Affordability%20Standards%20and%20Priorities%20for%20Health%20Insurance.pdf.

Standard 1: Primary care spending. The proportion of the insurers' medical expense to be allocated to primary care for the 12 months starting January 1, 2010, will be 1 percentage point higher (e.g., increase from 6% to 7% of medical expenses) than reflected in actual spending for the 12 months starting January 1, 2008. Specifically:

- Blue Cross Blue Shield of Rhode Island: 1 point increase by 2010 from 5.6 percent to 6.6 percent
- UnitedHealthcare: 1 point increase by 2010 from 7.3 percent to 8.3 percent
- Tufts Health Plan: 6.9 percent primary care spending by 2010. (There was no baseline for 2008 because the plan was new to the market. Standard was set at Rhode Island statewide commercial insurer average.)

The proportion will continue to increase by 1 percentage point per year for five years.

Each insurer must submit a plan to OHIC that demonstrates how the increase will be achieved. They must show that it will be accomplished without contributing to the increase of premiums, with an emphasis on innovative contracting and payment and primary care system investment, not merely fee schedule manipulation.[32]

Standard 2: Spread adoption of the chronic care model medical home. Insurers will support (with a commitment in writing) an expansion of either the Rhode Island Chronic Care Sustainability Initiative (CSI–RI) or an alternative all-payer medical home model with a chronic care focus. Support will start in July 2009 and continue through June 2010, with an increase of at least 15 full-time equivalent primary care physicians by the end of the period.[33] CSI–RI, also initiated by OHIC, is a voluntary multipayer chronic care model medical home initiative that involves all commercial and Medicaid carriers but not Medicare.[34]

Standard 3: Standard incentives to use electronic medical records. By January 1, 2010, insurers will demonstrate the implementation of an incentive program for physicians to adopt EMRs that meets the following standards:

- Initial payments per physician to subsidize the cost of EMR acquisition, adjusted for insurer market share, are as follows[35]:
  - Blue Cross Blue Shield of Rhode Island: $5,000 or more, up to a practice maximum of $15,000
  - UnitedHealthcare: $2,500 or more, up to a practice maximum of $7,500
  - Tufts Health Plan: $500 or more, up to a practice maximum of $1,500
- Ongoing financial support to a practice for the cost of EMR implementation, worth at least 3 percent more than the insurer's standard payments to the practice.

Insurers may establish an annual cap on enrollment in the EMR incentive program at not less than 200 new providers per year. This cap will be revisited annually by OHIC.

Standard 4: Work toward comprehensive payment reform across the delivery system. Insurers will commit in writing to participate in a state-facilitated process to explore, assess, recommend, and adopt reforms to health care service payment in Rhode Island, including:

- active engagement as a member of the stakeholder body to be convened by OHIC in coordination with other state governmental entities; and
- provision of noncompetitive information to the body to assist it in its deliberations.

Anticipated Impact of the Standards and Future Challenges

Rhode Island anticipates that the five-year collective impact of the standards will be an increase of $150 million to $200 million to primary care across the state—almost double the amount spent previously.

It is unclear how the insurers will respond to the requirement and make the investment in primary care. Two options are: straight rate increases for primary care providers and restructured payment arrangements (e.g., medical home supplemental payments beyond the requirement in the standards, enhanced pay-for-performance, etc.). OHIC has committed to a public process for the development of these investment plans. It also remains to be seen how the insurers will make the investment without driving up health care costs. Potentially, they could fund the increase through savings achieved from improved care management and delivery. Another option is to redistribute dollars from hospitals and specialists to primary care practices.

Evaluation Metrics

To evaluate the impact of the standards, OHIC developed a set of evaluation metrics, with plans to assess performance annually and to report results publicly (see Appendix). The use of systemwide metrics was designed not only to support evaluation but also to keep involved parties focused on the goals.

Issues to Watch

Rhode Island has produced a bold innovation by using state regulatory authority as a driver of health insurance reform. The state has addressed failure in the health care marketplace—evidenced by continued high levels of health cost inflation—by using regulation to drive changes aimed at improving affordability. These actions, coupled with prior steps to launch a multipayer medical home initiative, form an intriguing experiment. In the coming years, this experiment may serve to answer the following questions:

- Can state insurance regulation that is targeted at insurers' financial arrangements with providers significantly slow the growth in commercial health insurance premiums?
- Will limitations in the authority of OHIC—specifically the lack of regulatory authority over Medicare, Medicaid, and self-insured commercial coverage, which account for an estimated 45 percent of the state's covered population—constrain OHIC's ability to achieve its health care reform objectives?
- How will carriers respond? Do OHIC's affordability standards give insurers enough leverage to make necessary changes?
- Revitalizing primary care is a necessity, but not sufficient, delivery system reform. Will this effort make other needed reforms more likely in Rhode Island?
- Can carriers significantly increase the percentage of medical spending to primary care without increasing overall spending? If so, how?
- Will the standards achieve the desired behavior changes?
    - Will increased primary care spending increase the number of practicing primary care physicians in the state?
    - Will increased payment to primary care, coupled with a modest-sized chronic care model medical home initiative and EMR adoption incentives, produce improved primary care delivery?
    - How will specialty physicians and hospitals respond to the regulatory standards?

- As this effort is implemented, what are the implications for the private contracting model between provider and health plans? This process has taken a traditionally private contractual relationship and opened it to public review and oversight. Will this inhibit or promote innovation?
- Will any federal reforms that are passed increase or diminish the number and effectiveness of these state-led initiatives?

Regulation is a broader, blunter, and more direct form of state action than other state levers, such as purchasing or public exhortation. In setting the standards, Rhode Island surmised that without state regulatory action, systemic affordability initiatives were unlikely to happen. As other states grapple with the affordability problem and the role of health insurance regulation, time and experience will show whether Rhode Island's assumptions and efforts can provide insight and guidance.

NOTES

1 M. Kofman and K. Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change* (Washington, D.C.: Georgetown University, Apr. 2006).

2 National Conference of State Legislatures, *Managed Care State Laws and Regulations, Including Consumer and Provider Protections* (Washington, D.C: NCSL, Oct. 2008).

3 Rhode Island General Laws 27-19-6, 27-20-6, and 42-62-13.

4 Rhode Island General Law 42-14.5-2.

5 The council is a 16-member body that meets monthly between September and June and advises the Commissioner on regulatory standards. The council comprises employer, consumer, and provider representatives, as well as health policy expert consultants. It is cochaired by the Commissioner and one other council member. For more information, see www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_About.php (accessed Apr. 26, 2009).

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[16] D. Thompson and A. M. Wolf, "The Medical-Care Cost Burden of Obesity," *Obesity Reviews,* Aug. 2001 2(3):189–97; E. A. Finkelstein, I. C. Fiebelkorn, and G. Wang, "National Medical Spending Attributable to Overweight and Obesity: How Much, and Who's Paying?" *Health Affairs* Web Exclusives, Jan.–June Supplement W3:219–26.

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[22] A. Garber, "Evidence-Based Coverage Policy," *Health Affairs,* Sept./Oct. 2001 20(5):62–82.

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[29] By this, OHIC meant a medical home initiative that emphasized elements of the chronic care model. For more information on the relationship of the medical home to the chronic care model, see R. A. Berenson, T. Hammons, D. N. Gans et al., "A House Is Not a Home: Keeping Patients at the Center Of Practice Redesign," *Health Affairs*, Sept./Oct. 2008 27(5): 1219–30.

[30] For information on the Rhode Island Chronic Care Sustainability Initiative (CSI-RI), see www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_02_13_medical_home_case_study_presentation.ppt.

[31] The experts participating in a Feb. 23, 2009, conference call with OHIC included John Colmers, secretary of the Maryland Department of Health and Mental Hygiene, Michael Cropp, M.D., president and CEO of Independent Health, Glenn Steele, M.D., Ph.D., president and CEO of Geisinger Health System, and Anne Gauthier, assistant vice president, and Cathy Schoen, senior vice president, The Commonwealth Fund.

[32] It was the general opinion of the council that increases in primary care fee schedules should be a necessary component, but would not be sufficient to meet the standard. That is, the standard could and should result in an increase in primary care fee schedules to better attract and retain primary care physicians in Rhode Island. The standard, however, will not successfully improve affordability unless this investment includes more innovative payment models that move beyond the traditional fee-for-service system. The council made no specific recommendations about the alternatives, but referred to models in the literature and in practice in other communities, including pay-for-performance incentives, case management fees, and carefully conceived risk-sharing mechanisms.

[33] The addition of 15 full-time equivalent physicians would increase the patients affected by the program, as a percentage of the total state population, from 2.38 percent to 3.69 percent, the latter being the national multipayer medical home benchmark level that Pennsylvania intended to achieve in 2009.

[34] Office of the Health Insurance Commissioner, State of Rhode Island, www.ohic.ri.gov/Press_IntheNews_CSI_2008.php. (accessed Aug. 31, 2009).

[35] Based on a per-physician EMR adoption cost of $33,000, a target of 25 percent overall subsidy, and market shares of 62.5 percent/32.5 percent/5 percent, respectively.

[36] Survey of all physicians in Rhode Island (6.9% response rate). OHIC intends to modify the instrument to capture physician specialty and increase the response rate.

[37] Blue Cross Blue Shield of Rhode Island, measured as of June 2008. Includes physician assistants, nurse practitioners, primary care physicians (PCPs), and specialists who also serve as PCPs and receive PCP fees for primary care services. UnitedHealthcare provided a comparable estimate

[38] Kaiser Physician Counts, Dec. 2007.

[39] K. Williams and J. Buechner, "Hospitalizations for Ambulatory Care Sensitive Conditions," *Health by Numbers* (published by the Rhode Island Department of Health), Mar. 2005 7(3). Data from Exhibit 3 (Discharges for Ambulatory Care Sensitive Conditions as Percent of All Discharges, by Age Group and Insurance Status, Rhode Island Residents, 2001–2003). Note that benchmark is for commercial insured population only, but the Rhode Island statistic is across all populations. Carriers will self-report commercial data for ongoing assessment.

[40] 2000 AHRQ data obtained at www.ahrq.gov/data/hcup/factbk3/fbk3fig6.htm.

[41] C. M. DeRoches, E. G. Campbell, S. R. Rao et al., "Electronic Health Records in Ambulatory Care, A National Survey of Physicians," *New England Journal of Medicine*, July 3, 2008 359(1):50–60; Physician Health Information Technology Survey Pilot Results, Oct. 29, 2008. OHIC calculated 7.2 percent as a lower estimate for the general physician population to address a likely nonresponse bias in the Rhode Island Department of Health survey (i.e., those who have EMRs would be more likely to respond to an EMR survey) http://www.health.ri.gov/publications/qualityreports/physicians/HealthInformationTechnology/SummaryReport2008.pdf.

[42] Rhode Island Quality Institute. Carriers will not be held accountable for increased adoption rates, but will have to show that they have an incentive program in place.

Appendix. Evaluation Metrics

Metrics for Standard 1: Primary Care Spending

- Primary care satisfaction (OHIC annual survey)
  Baseline: 30.8 percent of all providers satisfied with reimbursement[36]
- Primary care supply: number of total primary care providers
  Baseline: 1,035 total primary care providers in Rhode Island[37]
  Baseline: 33.5 percent of Rhode Island physicians identified as primary care physicians[38]
- Primary care supply: primary care physicians as a percentage of Rhode Island physicians
  Baseline: to be reported by the insurers
- Incidence of hospitalizations for ambulatory care–sensitive conditions (Agency for Healthcare Research and Quality)
  Current Rhode Island incidence: 16.6 percent of all Rhode Island hospitalizations of insured patients[39]
  National benchmarks: 11 percent of all hospitalizations of commercially insured patients[40]
- Incidence of emergency room visits for ambulatory care–sensitive conditions
  Baseline: to be reported by the insurers in annual metrics report
- Overall Rhode Island medical trend, for fully insured, commercial business
  Metric will be based historical data filed as part of commercial filings

Metrics for Standard 2: Spread Adoption of the Chronic Care Model Medical Home

The Chronic Care Sustainability Initiative project has programmatic goals for improved performance on quality measures for three chronic conditions—coronary artery disease, diabetes mellitus, and depression—as well as for reduced emergency room visits, inpatient readmissions, and system costs. In addition, a third-party evaluation, funded by The Commonwealth Fund, is being conducted as part of the project.

Metric for Standard 3: Standard Incentives to Use Electronic Medical Records

- EMR adoption vs. national benchmark
  Currently somewhere between 7.2 percent and 14.8 percent of all Rhode Island licensed physicians have adopted an EMR vs. 13 percent nationally[41,42]

Metric for Standard 4: Work Toward Comprehensive Payment Reform

OHIC did not define a metric for this standard. It remains to be developed in future years.

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