

Office of the Health Insurance Commissioner
July 2010 Rate Factor Decision
Additional Conditions

Background

Conditions were attached to the approval by OHIC of rate factors to be used by commercial insurers for calculating small and large group employer insurance rates in 2011.

The conditions address the implementation of OHIC's "Affordability Standards".¹ These standards have as their goal provider payment reform, which OHIC's Health Insurance Advisory Council states is essential to the long-term affordability of health insurance. Data presented by the health insurers in their most recent filings with OHIC makes it apparent that 40% of health insurer medical costs are spent on hospitals, and that in almost every case inpatient and outpatient hospital expenses are inflating faster than any other medical service category. Moreover, previous studies by OHIC have documented variations in rates of payment for commercially insured enrollment of up to 85% for the same sets of service to varying institutions – a variation insurers report to be much greater than for physician services and raising question regarding the fair treatment of hospital providers under the current private contracting model.² Similar concerns have been noted in Massachusetts.³ These facts indicate that current health plan contracting with hospitals have not been an effective policy to improve the affordability of commercial health insurance premiums – a statutory directive of OHIC.

For these reasons, these conditions focus on the terms of health plan contracts with hospitals and attempt to promote and facilitate the goal of provider payment reform as set forth in OHIC Affordability Standards.

Conditions

For all health plan contracts with hospitals licensed in Rhode Island, which expire between now and June 1, 2011, subsequent contract terms for commercially-insured enrollment must accomplish the following:

1. Utilize unit of service payment methodologies for both inpatient and hospital

¹ OHIC Affordability Standards, June 2009:
http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/5_HIAC%20Report%20-%20System%20Affordability%20Stds%20&%20Priorities%20for%20Insurers.pdf

² OHIC: Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island, Office of the Health Insurance Commissioner, January 2010

³ Massachusetts Attorney General: Examination of Health Care Cost Trends and Cost Drivers, Pursuant to G.L. c. 118G, § 6½(b). Report for Annual Public Hearing, March 16, 2010

outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service, i.e. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.

- Efficiency-based payment methodologies, and their superiority over traditional per-diem arrangements are well documented in publications by the Medicare Payment Advisory Commission. Many of these have either been implemented by Medicare already or are being demonstrated. OHIC's recently completed insurer contracting survey however, documented the lack of their use in Rhode Island.

2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract.⁴ The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year.

- The Hospital Input Price Index has been adopted by CMS as an appropriate measure of fair price increases for Medical Services. It was recently adopted by the Rhode Island legislature as well for Medicaid payments to hospitals. Filings with OHIC by the insurers, however, consistently document price increases to hospitals at several multiples of this index. These differences are passed directly onto commercial insurers and raise commercial insurance prices.

3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.

- Performance-based opportunities for hospital revenue enhancement are not uncommon, and yet Rhode Island insurers reported as part of this rate review process they constitute only 0.5% of their payments to hospitals. The appropriate size and content of performance-based opportunities for hospital revenue enhancement should be subject to private negotiation, however the relatively low usage rate of such payment enhancements in Rhode Island has hindered broader payment realignment.

⁴ Available at <https://www.cms.gov/MedicareProgramRatesStats/downloads/mktbskt-pps-hospital-2006.pdf>

4. Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify explicit commitments on the part of each.

- Insurers, hospitals, and national studies alike all point to excess administrative costs as a problem. Insurer administrative costs are now rising at rates of insurance premium inflation, several times the rate of general inflation.

5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

- The Department of Health's Primary Care Provider Advisory Committee has consistently identified opportunities for improvements by institutions in this area that would improve the quality and efficiency of care and reduce the use of preventable emergency room and inpatient hospital care. Health insurer contracts are appropriate means to promote these goals.

6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

- To achieve the goals set forth in OHIC's Affordability Standards, greater degrees of public accountability and transparency for health plan payment terms and conditions with hospitals – similar to those in place for Medicare and Medicaid – are necessary.

Nothing in the requirements is meant to require that health plans must contract with all hospitals licensed in Rhode Island. Consistent with statutes enforced by the Department of Health, insurers must demonstrate adequacy of their hospital network.

Enforcement

By law OHIC has access to all provider contracts of an insurers. Health insurers who fail to meet these conditions will face consequences as allowed by law and deemed appropriate by the Commissioner