RHODE ISLAND'S NOVEL EXPERIMENT

REBUILDING PRIMARY CARE FROM THE INSURANCE SIDE*

Delaware Health Care Commission

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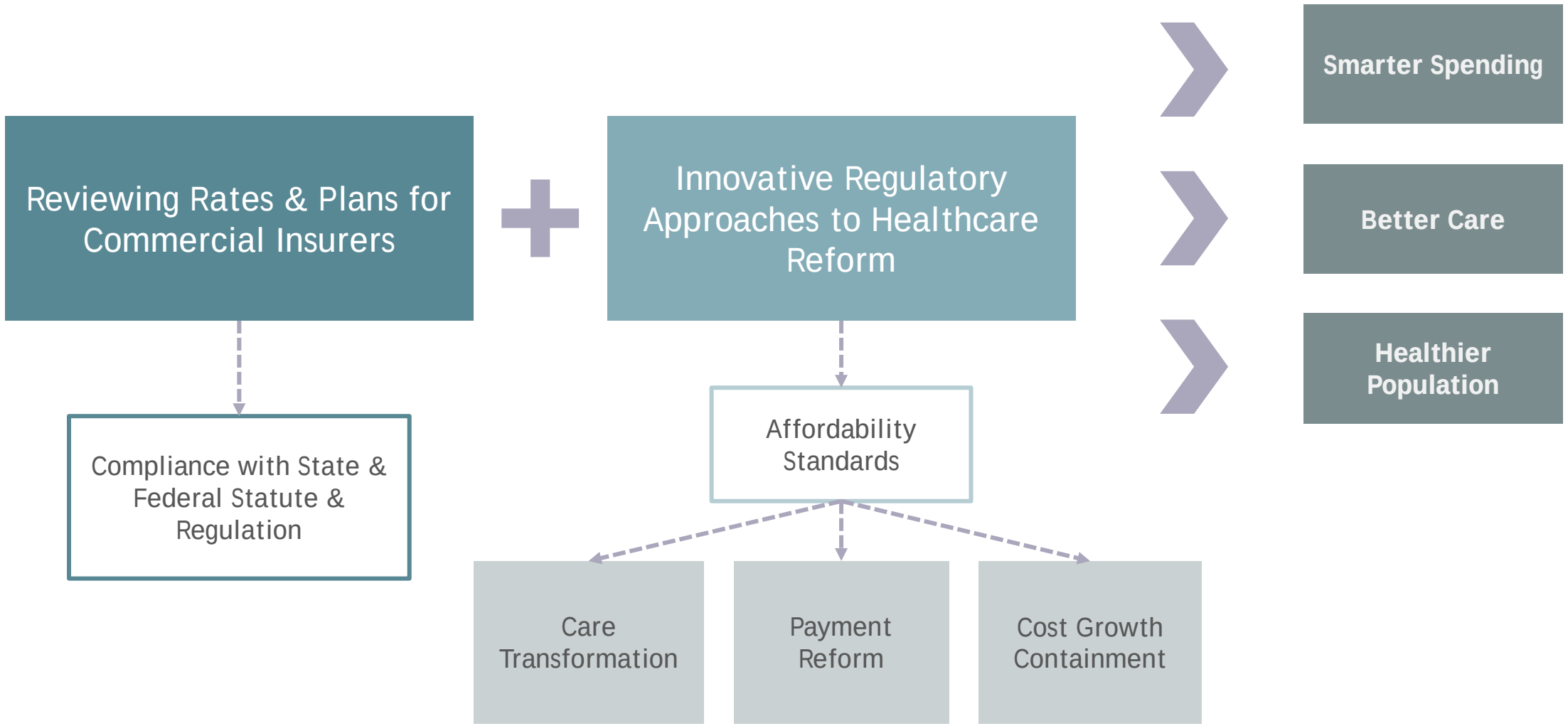
Health Insurance Commissioner

OHIC's Statutory Charge

OHIC was created by the legislature in 2004 with the specific charge to:

- Guard the solvency of insurers
- Protect consumers
- Encourage fair treatment of providers
- Encourage policies that improve the quality and efficiency of health care service delivery and outcomes

OHIC Theory of Action



Insurer Affordability Initiatives & The Role of Regulation

In 2008, OHIC began to hold insurers accountable for implementing policies that improve health care affordability by leveraging the annual rate review process.

Rationale:

1. Insurer activities can affect medical cost trends.

2. Reasonable alignment of policies and actions by insurers is possible and beneficial to achieving systemic goals. Without alignment, insurers' affordability efforts limited by ability and willingness of each insurer to influence change.

3. Communities can identify system priorities in public discussion of trade-offs.

Framing the Affordability Standards

OHIC was advised by its Health Insurance Advisory Council to focus on primary care transformation. Council recommended 4 priorities ***to guide insurer action*** to advance health care system transformation broadly:

1. Expand and improve the primary care infrastructure
2. Promote the adoption of patient-centered medical homes
3. Promote the adoption of electronic health records by physicians
4. Implement more comprehensive payment reform

These recommendations became regulatory requirements for insurers to follow.

The Affordability Standards

Beginning in 2010, each major insurer was required to:

1. Increase the percentage of total commercial medical payments allocated to primary care by 1% per year above their 2008 baseline, for 5 years;

2. Support expansion of RI's all-payer PCMH program (investments counted toward the annual primary care spend target).

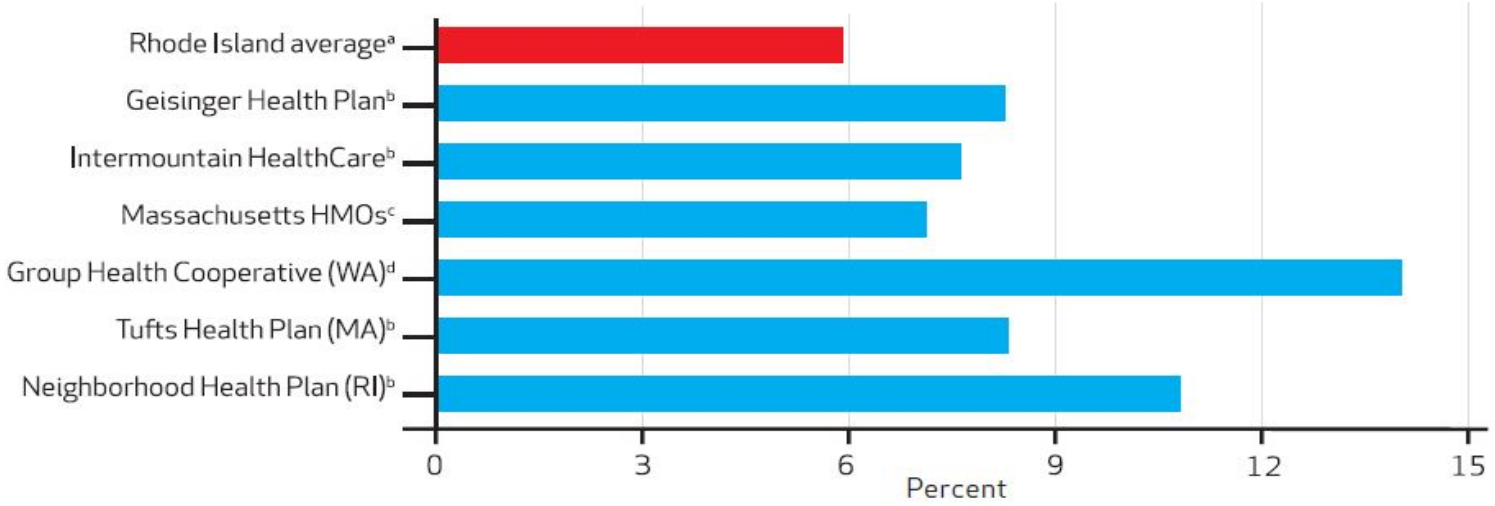
3. Invest in the adoption of electronic medical records by primary care physicians and to support the development of the state's Health Information Exchange (counted toward primary care spend target).

4. Engage in ongoing discussions on comprehensive payment reform; later, included a regulatory cap on annual hospital fee schedule increases for commercial insurance.

The 2008 Primary Care Benchmarking Analysis

EXHIBIT 1

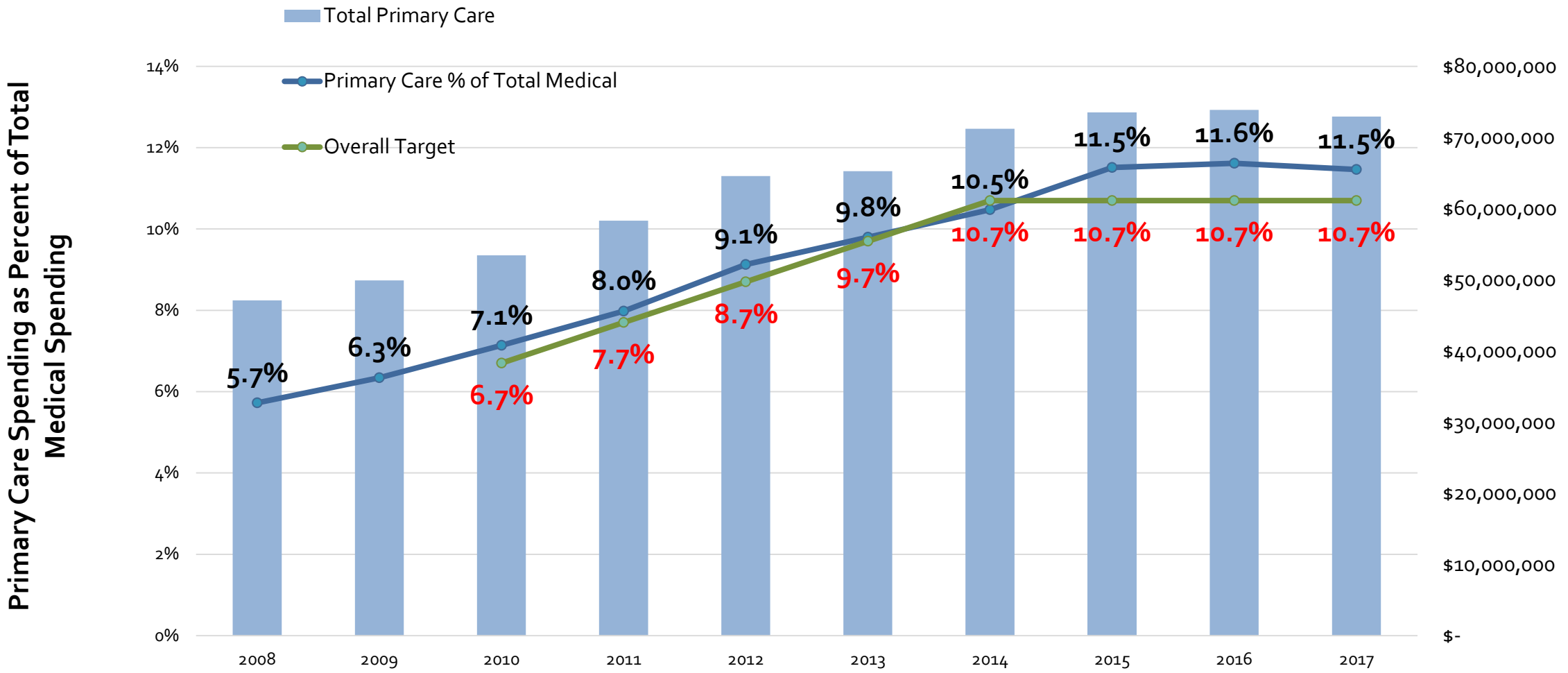
Primary Care Spending As A Percentage Of Total Medical Spending, Rhode Island Average (Baseline) And Benchmarks From Six Large Insurers



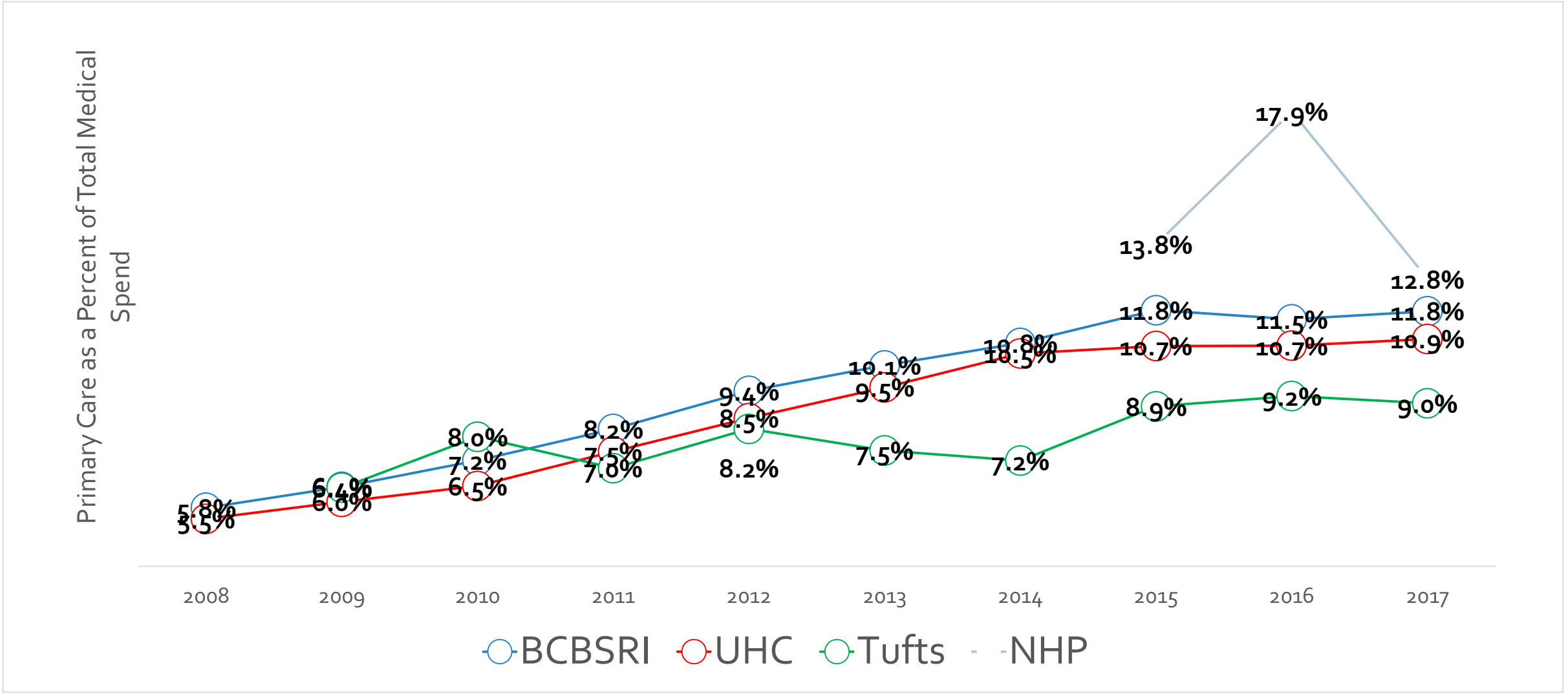
SOURCES Office of the Health Insurance Commissioner, Rhode Island; and various other sources (see below). **NOTES** The Rhode Island average is the mathematical average of the two largest commercial insurers in the state, Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England. The Rhode Island target is 10.9 percent, which is the current rate plus five percentage points, as set in affordability standards. [a]Plan-specific spending rates are greatly influenced by membership mix. [b]Source: Self-reported by insurers. [c]Source: Oliver Wyman Study, 2008 Sep, based on commercial, fully insured health maintenance organizations (HMOs) only. Primary care includes obstetrics/gynecology; excludes pay-for-performance. [d]Source: Wagner EH, director of the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative. Group Health Cooperative is a group-model HMO with owned facilities, like Kaiser Permanente.

WHAT HAPPENED TO PRIMARY CARE SPENDING IN RHODE ISLAND?

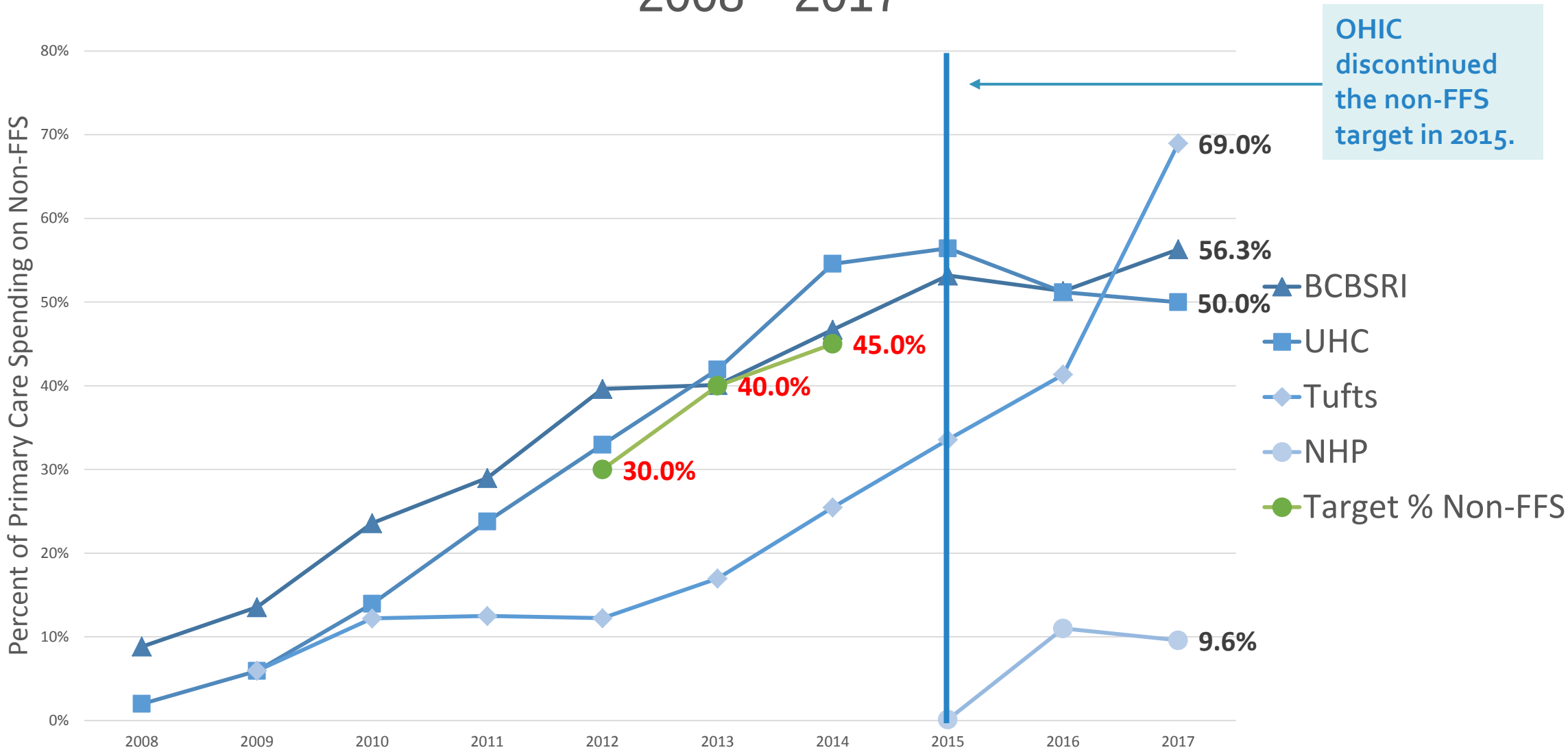
Primary Care Spending, Total and as Percent of Total Medical Spending, 2008 – 2017



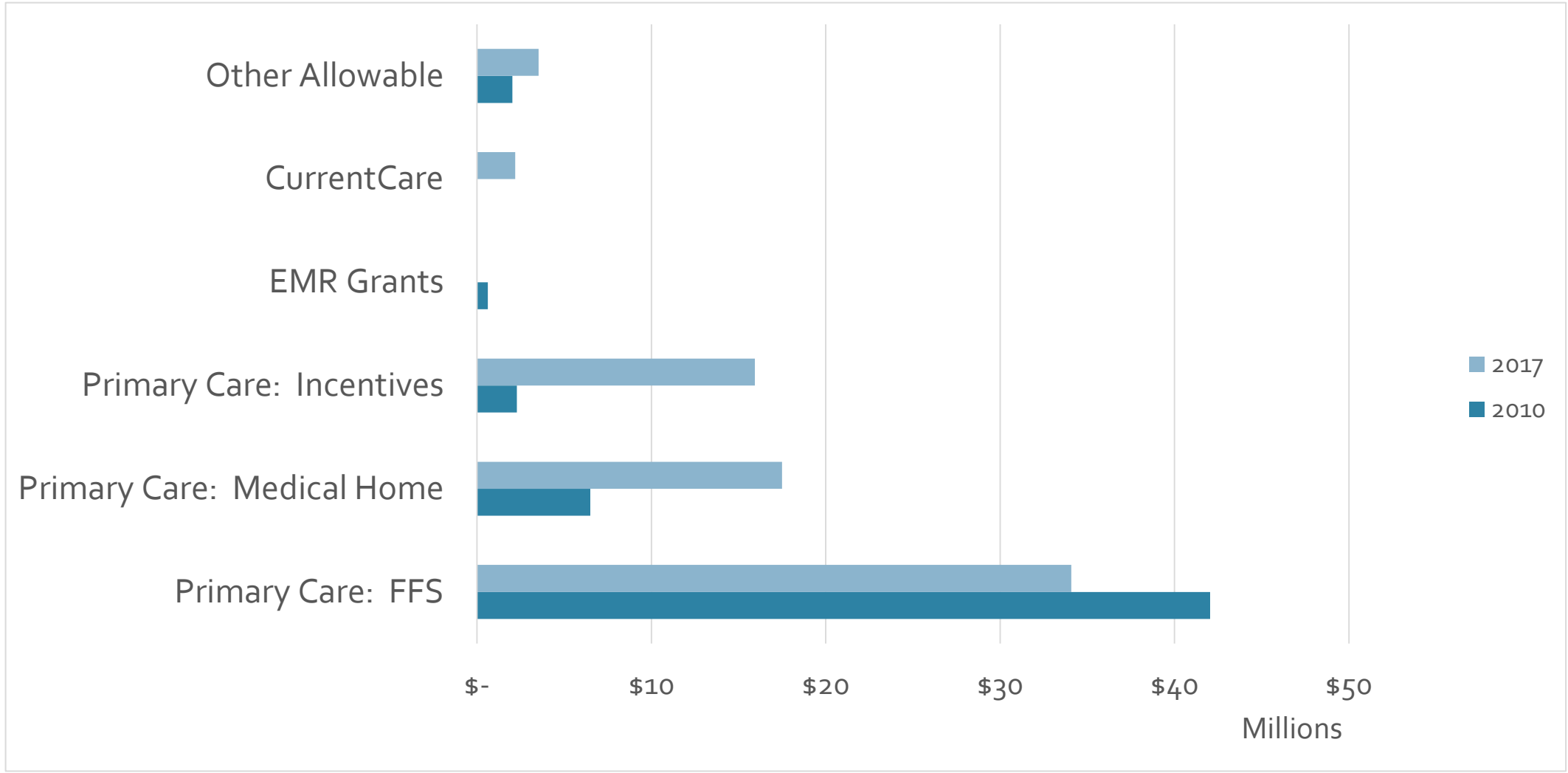
Primary Care Spending as Percent of Total Medical Spending by Insurer, 2008 – 2017



Percent of Non-FFS Primary Care Spending by Insurer, 2008 – 2017



Primary Care Spending by Category, 2010 and 2017



The Affordability Standards Today

Care Transformation	• Primary care spending shall be at least 10.7% of total medical spending. • Insurers shall have a required percentage of PCPs practicing in a PCMH, increasing each year. • OHIC convenes a Care Transformation Advisory Committee annually.
Payment Reform	• OHIC requires that at least 50% of medical payments should be under an alternative payment model. • OHIC defines minimum downside risk thresholds in total cost of care contracts. • OHIC convenes an Alternative Payment Methodology Advisory Committee annually.
Cost Growth Containment	• Hospital rate increases for commercial business shall not exceed CPI-U % plus 1%. • Accountable Care Organization total cost of care budget increases capped at the CPI-U % increase plus 1.5%. • Annual Overall Cost Trend Growth Target Planning Underway

Laying the Foundation for Future Transformation

What did the primary care spending requirement accomplish?

Care Transformation

- Over 50% of contracted PCPs are practicing in a PCMH.
- Primary care investments have helped fund the development of ACOs.
- PCMHs are taking on innovative care delivery models, such as integrated behavioral health care.

Payment Reform

- Primary care practices are better positioned to engage in alternative payment models.
- Over 50% of contracted PCPs are engaged in total cost of care contracting through ACOs.

Lessons Learned*

- Use evidence in public conversation to support policy objectives
- Showcase examples of what works
- Adapt to community characteristics– -staying focused on the goal
- Measure before and after intervention; use data transparently
- Adjust policy as needed– -staying focused on the goal
- Use all of the above to set goals and garner support

Questions?

References

*Koller, C. F., Brennan, T. A., & Bailit, M. H. (2010). Rhode Island's Novel Experiment To Rebuild Primary Care From the Insurance Side. *Health Affairs, 29*(5), 941-947.