Address: Delivery System Reform in Rhode Island

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Senate Health Education, Labor and Pensions Committee

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Members of the Committee:

Thank you for the opportunity to address you on this important topic. Thank you especially to Rhode Island's Senate Delegation – Senators Reed and Whitehouse. Senator Reed, formerly a member of this committee, is strong advocate for preserving and enhancing insurance coverage, and Senator Whitehouse has immersed himself in the critical topic we are discussing today. Both are committed public servants. Rhode Island is fortunate and privileged to be represented by them.

In my address today, I want to cover three topics related to medical care delivery system reform: the role of the Office of Health Insurance Commissioner, our work on delivery system reform, and what some of our lessons learned have been.

The Office of the Health Insurance Commissioner was established by law in 2004 in response to concerns about the behavior of Rhode Island health insurers, and a recognition of the fundamentally different nature of health insurance from any other type of insurance. I have occupied the position since it was first filled in 2005. I am the only Health Insurance Commissioner in the country. Central to the Office are its statutory duties, which form the legal basis for our work. In addition to the customary insurance regulator responsibilities of guarding the solvency of insurers and protecting the interests of consumers are two broader and critical duties:

- To assure fair treatment of providers; and
- To see the Rhode Island's healthcare system as a whole and to direct insurers towards policies which improve the affordability, accessibility and quality of the system.

Although there is little statutory direction behind those stated duties, our actions in payment reform are firmly grounded in these standards.

The Office's primary tool for this work has been the annual review of rates commercial insurers in the state. There are three components to that review:

- It is comprehensive – covering small group and large group business for all carriers – and prospective – rates must be approved before being used.

- It examines rate factors, not product prices. By rate factors we mean the carriers' estimated inflation rates for price and utilization for five medical service categories – hospital inpatient, hospital outpatient, primary care, pharmacy and all other medical. In addition, we look at their estimated administrative costs and projected profits.

- It is simultaneous for all carriers, public, and transparent. As a result, we can both educate the public about what is driving the increases in their health insurance premiums (documenting, for instance, last year's attributed inpatient price increases of about seven percent, while utilization was almost flat) and query carriers about significant variations between them in inflation rates and administrative costs.

Rate review forms the basis for our systemic delivery system reform efforts. Specifically, after several years of this work, it became apparent to the Office's Health Insurance Advisory Council, a statutorily charged group of employers, consumers and providers who advise the Office, that rate review alone would not reduce the rate of increase in commercial health insurance premiums; that the true costs were in the delivery system and insurers would need direction and coordination in this work.

Specifically: transparent, comprehensive rate factor review highlighted that:

- Medical costs constitute about 85% of the typical insurance premium.

- Insurers were predicting medical cost increases of eight to ten percent annually, driven by increases in both price and utilization of services; and

- Insurers have limited tools to change those trends - given the prevailing fee for service payment system, medical providers with market power to resist insurer changes, fragmented providers who cannot coordinate care well, and patients who have no incentives to choose better performing systems of care.

Given these facts, the Advisory Council then worked to identify four Affordability Standards – actions which must be taken by any commercial insurer in Rhode Island as a condition of receiving rates. In brief, these Standards consist of:

1. Health insurers must increase the portion of their medical expenses going to primary care by one percentage point a year for five years.

   Primary care is the only part of our medical care system where the more we have, the lower our population costs and better a community's health (two thirds of Dr. Berwick's triple aim). But nationally we only spend about seven percent of our medical expenses on it. Why is this? The answer has to do with how Medicare sets rates and who has economic power in private contract negotiations. We did not like that answer in Rhode Island and so we have set about to change it by telling health plans they must invest in primary care on behalf of the community. Two years later, we are seeing the

results – the money is being spent on things like establishing patient centered medical homes and primary care docs in Rhode Island are happier and better able to recruit peers to come here and work.

2. Standard number two deals with health insurer support of our all-payer, patient centered medical home project.

   Patient Centered Medical Homes are a well-publicized attempt to define what constitutes high quality primary care, capable of coordinating the care of our most expensive chronically ill patients. They work, but take money and time to be built. The money must come from insurer payments and must be coordinated to pay for the same things – providers hate being jerked in different directions by the conflicting demands of different carriers. Rhode Island's Chronic Care Sustainability Initiative is six years old and touches 70,000 patients. We have documented significant improvements in the quality of care provided, have signs of improved utilization experience and built a cadre of primary care leaders.

3. The third affordability standard coordinates health plan investment in and support for health information technology.

   Under the leadership of the Rhode Island Quality Institute and Senator Whitehouse, Rhode Island has used to federal ARRA money to make significant investments in Electronic Health Records adoption, a Health Information Exchange and – as a Beacon community – implementation of this work to improve the quality of care delivered. This Affordability Standard makes sure that your initial federal investments in Rhode Island are matched and followed up by private insurer money as well, so we sustain this critical work.

4. The final Affordability Standard addressed hospital payment reform.

   Work by my Office has documented private insurer payment variations of 100 percent to different hospitals for the same services. This difference appears to be driven only by hospital size and negotiating power. In addition, there is a marked gap between the theory of hospital payment reform and the practice in Rhode Island – with most payments occurring on a fee for service basis with little or no quality incentives. Given insurer inability or unwillingness to implement hospital payment reform, OHIC set forth six conditions which must be included in future health plan contracts with hospitals. These included limiting price increases to Medicare CPI, installing quality incentives, and facilitating efficiency-based payments such as Diagnosis Related Groups. One year in, and it appears insurers and hospitals are adopting these standards, and a recent court ruling upheld the Office's ability to change health plan contract terms with hospitals.

This is just a brief summary of the Office's attempts to promote delivery system reform. And we make no claims of success, yet. Our premiums still continue to climb. Our evaluation and measurement efforts are incomplete. Our interagency coordination could be better. But I would offer these lessons from our work to date.

1. Delivery system reform must make primary care infrastructure development its first priority.

   Every high performing health system in the world has a fundamental commitment to primary care and puts their money in this direction. The US does not. Delivery system reform of course must extend beyond this, but at the core of integrated, accountable delivery systems must be primary care.

   Primary care is also the link or "hinge" to public health and the personal behaviors, which constitute a far greater driver of community health and community costs than the medical delivery system.

2. Delivery System Reform will not happen without public oversight.

   Commercial insurance rate review is a good start for this oversight but is not sufficient. We have to make it in the economic interests of providers to change behaviors. In Rhode Island, I had to survive a court suit to nullify a contract term between a market-dominant hospital and a local insurer, which would have explicitly shifted all self-determined losses for Medicaid and Medicare back to the insurer and commercial rate payers. This term was only possible because of the hospital's market dominance.

   We must change the rules of success for providers, while respecting how difficult it is for large institutions to change. This not merely about government price controls, but using government authority to promote new provider payment methods – such as bundled payments and carefully monitored capitation – that change the success rules and encourage providers to coordinate high quality care together, not just produce more volume alone.

3. Delivery system reform efforts must be coordinated across payers.

   An iron law of commerce is that behavior follows reimbursement. But in Rhode Island and elsewhere, commercial health insurance only constitutes 20% of the population and money in the system Medicaid and Medicare are worth 50%, self insured are worth 20% and the uninsured another 10%. As a result, in almost all instances, no payer by itself has enough economic influence to change provider behavior and promote delivery system reform and such efforts must be coordinated across payers. This is hard work, and involves changing contracting culture and

providing antitrust protection. It also means coordinating with Medicare – no easy task. In Rhode Island, we are proud that our all-payer medical home effort has been selected by CMS to participate in the Medicare Advanced Primary Care Practice (MAPCP) demonstration project, and encourage expansion of this work. We are also looking for ways to coordinate commercial hospital contracting with the upcoming Medicare payment changes.

Finally, based on these lessons, what are some actions Congress could take to encourage further delivery system reform? I offer four areas, all of which build on the significant federal investments being made in information technology:

1. Make primary care a systematic priority – in loan forgiveness and education, in Medicare payments, in health services research and NIH funding, in HRSA budgets. Our budgets are our values statements and the federal government does not value primary care.

2. Support Medicare payment innovation. Although not directly in this Committee's jurisdiction, Medicare is a powerful force in delivery system reform. The ACA has numerous payment innovations and sets up structures for more. IPAB must be protected and the Center for Medicare and Medicaid Innovation encouraged, funded and allowed to put forth projects with long payoff estimates.

3. Support multipayer alignment.

    - CMS must be directed to coordinate its efforts better across Medicaid and Medicare.

    - More directly in this Committee's responsibilities, states should be encouraged to expand rate review efforts to align commercial insurers with public payers. Finally, almost 30 percent of RI's population is enrolled in self-insured plans, which can exempt themselves from all-payer efforts. The ERISA pre-emption clause is a major barrier to delivery system reform.

4. Create incentives for patients to select high-value delivery systems. Because the costs of health insurance are subsidized by employers and the government, individuals do not pay the full costs of wide provider choice, and undervalue the efficiencies and effectiveness of integrated delivery systems. Developing and standardizing effectiveness measures using resources such as the new Patient-Centered Outcome Research Institute, equalizing tax policies for health benefits, promoting individual purchase on exchanges, and designing Medicaid, Medicare and FEHBP benefits that promote price sensitivity will all create these incentives.

Since we pay for technical procedures and specialists, we should not be surprised that we get a lot of volume and specialty care, and less value than other countries. The US multipayer system

makes it hard to change, but our work in Rhode Island shows that it can be done. Innovating states need the help of Congress in these efforts.

Thank you again for the chance to address the Committee. I look forward to answering your questions.