

## The Performance of Rhode Island's Commercial Health Plans, 2005

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**Comparative information on health plan performance is useful** to plan members, purchasers, regulators, and policy-makers. To meet the needs of all users, the comparative measures must cover the general areas of cost, quality, and access to care. In response to this need for information, the Rhode Island General Assembly passed the Health Care Accessibility and Quality Assurance Act in 1996 (Rhode Island General Laws 23-17.13).<sup>1</sup> The Act instituted health plan performance reporting in the state, which is summarized annually, most recently in *Rhode Island Health Plans' Performance Report (2005)*.<sup>2</sup> The information presented here is derived primarily from that report.

### METHODS

The Rhode Island Department of Health's Center for Health Data and Analysis uses an annual survey to collect health plan data from three primary audited sources: Statutory Filings to the state's Department of Business Regulation, **Health Plan Employer Data and Information Set (HEDIS)** reports, and **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** reports.

Twenty-seven measures are evaluated, comprising seven dimensions of performance (enrollment, utilization, prevention, screening, treatment, access, and satisfaction). The measures are both trended over time and compared to average New England values. To supplement this information, financial data on premiums were extracted from the National Association of Insurance Commissioners' health database.

### RESULTS

Rhode Island's commercial health insurance market is concentrated in two carriers, Blue Cross and Blue Shield of RI (Blue Cross) with a market share of 65%, and United Healthcare of New England (United) with a share of 17%. The remainder of the market (18%) consists of a number of smaller plans, none of which are domiciled in Rhode Island.

To assess whether the purchasers of these plans' products are receiving 'value' one must necessarily examine its two components, cost and quality. On average, commercial health insurance

costs less in Rhode Island (RI) than in New England (NE). (Figure 1) Blue Cross monthly premiums were 6% lower than regional premiums (\$302 vs. \$321) and United premiums were 10% lower (\$288 vs. \$321). In addition, RI plans spent less on medical services (4% less for Blue Cross and 17% less for United), and they were less profitable than their NE peers (49% lower for Blue Cross, and 10% lower for United).

With few exceptions, both RI health plans performed relatively well on clinical quality measures. (Table 1) Blue Cross' and United's quality results were remarkably similar when compared to the regional experience. Each plan fell unfavorably below the NE values on four of the 15 measures (27%) and matched NE values on all the remaining measures but one, for which United exceeded the NE value. Given that health plans in New England, taken as a group, consistently post the highest quality (and satisfaction) scores in the country, the regional comparison provides a rigorous benchmark for local plans. However, no matter how acceptable an individual plan's relative performance, the absolute values on some clinical measures are concerning. For example, the low *Chlamydia Screen-*

**Table 1.**  
Health Plan Clinical Performance Measures, Blue Cross of Rhode Island, United Healthcare of New England, and New England Region, 2005

Dimension/Measure	New England Region	Relative to New England Region	
		Blue Cross	United
<b>Prevention</b>			
Childhood Immunization	81.2%	=	=
Adolescent Immunization	77.4%	-10%	-9%
Advising Smokers to Quit	76.6%	=	+7%
<b>Screening</b>			
Colorectal Cancer Screening	63.6%	=	=
Breast Cancer Screening	79.0%	=	=
Cervical Cancer Screening	86.4%	-5%	=
Chlamydia Screening	39.5%	=	=
Diabetes: Eye Exam Screening	68.0%	=	-11%
Diabetes: HbA1c Tested	91.0%	=	=
<b>Treatment</b>			
Diabetes: HbA1c Controlled	74.0%	-10%	-9%
Beta Blocker Treatment	98.1%	=	=
Antidepressant Medication Management	29.6%	=	-14%
<b>Access</b>			
Follow-up for Mental Illness	83.4%	-12%	=
Well Child Visits	83.2%	=	=
Adolescent Well-Care Visits	57.8%	=	=

Note: "±" indicates that the relative difference from the New England rate is no more than +/- 5%.

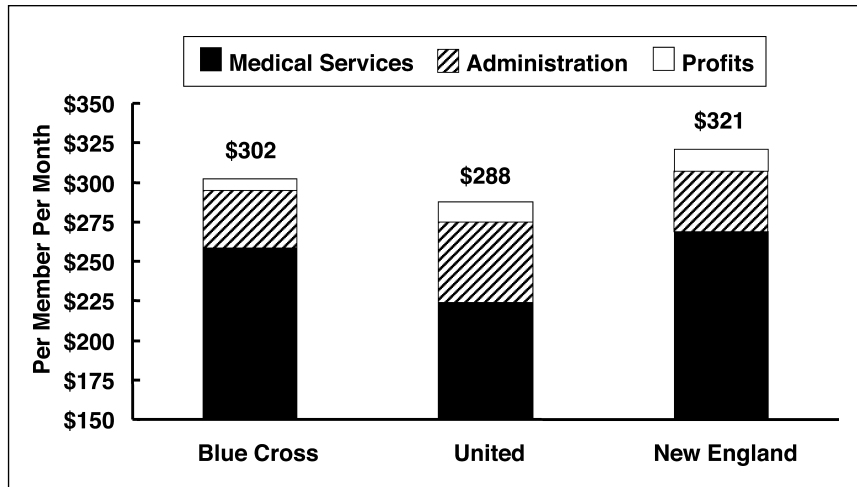


Figure 1. Average health plan premium per member per month, by component, Blue Cross of Rhode Island, United Healthcare of New England, and New England Region, 2005.

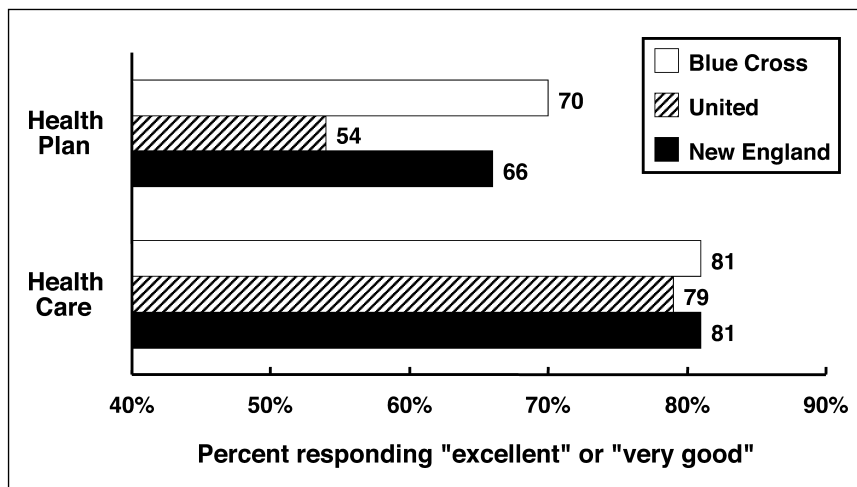


Figure 2. Health plan member satisfaction with health plan and health care, Blue Cross of Rhode Island, United Healthcare of New England, and New England Region, 2005.

ing values (Blue Cross: 37.6%; United: 39.2%) and *Antidepressant Medication Management* values (Blue Cross: 31.9%; United: 25.3%) highlight the need for further improvement in these areas.

The nexus between low cost and high quality is ‘value,’ and it appears that both Blue Cross and United are providing good ‘value’ to their commercial customers. Whether or not that ‘value’ is perceived by the members of those plans is another matter. (Figure 2) Member satisfaction with Blue Cross was 4 percentage points higher than the regional rate (70% versus 66%), and member satisfaction with United was 12 percentage points lower than that comparable (54% versus 66%). Therefore, there appears to be a “disconnect” between the favorable performance measures for United and its low member satisfaction rate.

There was no significant difference in member satisfaction with healthcare services between the plans and the New England rate. This is significant in that members must believe they are receiving quality services for them to be effectively provided. Interestingly, regardless of geographic area or health insurer, more members were satisfied with their healthcare services than with their health plans.

## DISCUSSION

Increasingly, the public, purchasers, providers, and policy makers are requiring meaningful information about health plans. Since 1998, the Department of Health has tracked the performance of this industry and produced annual reports on the subject.

With the small number of health plans in the state and the market dominance of Blue Cross, most Rhode Islanders have limited choice of carrier. The lack of widespread selective contracting also means that most plans deliver services through a similar network of physicians, hospitals, and other providers.

Therefore, the real value in publishing this information is less in aiding consumer choice and more in fostering accountability of the industry. Purchasers deserve to know how well the plans are performing and policy makers need empirical evidence to set effective policy. An added benefit is that the performance of health plans will likely improve if for no other reason than the results are made public.

## REFERENCES

1. See <http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.13/INDEX.HTM>.
2. Cryan B. Rhode Island Health Plans' Performance Report 2005. Providence RI: Rhode Island Department of Health and Office of the Health Insurance Commissioner. April 2007. See <http://www.health.ri.gov/chic/performance/commercial-2005.pdf>.

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