



HealthSource Rhode Island: Status Updates and Upcoming Policy Choices

October 2014



RIPEC

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Executive Summary

On September 19, 2011, Governor Lincoln D. Chafee signed Executive Order 11-09, which established Rhode Island's health benefits exchange as a division within the Executive Department. Rhode Island opened its online marketplace, HealthSource Rhode Island (HSRI) on October 1, 2013, and as of August 2, 2014, HSRI had registered 26,686 enrollments, including 25,892 paid enrollments in its individual market.

Although the Executive Order creating HSRI relies upon existing statutory authorities in Rhode Island General Laws¹, HSRI remains an executive branch entity that has not been separately established in the Rhode Island General Laws. As of July 2014, Rhode Island was one of four states with state-based exchanges that applied, and was approved to continue spending federal revenue into 2015. Long-term, non-federal funding sources beyond FY 2015 remain unknown, despite a mandate from the U.S. Department of Health and Human Services (HHS) that state-based exchanges provide HHS with a "long-term operational cost analysis and sustainability plan including specific activities with a timeline to assure the self-sustaining requirement of the Exchange is met."² The necessity to provide HHS with this information, and the reality associated with the need to fund HSRI with non-federal sources, presents Rhode Island stakeholders with a set of upcoming policy choices about the intended functions of HSRI, and the corresponding funding levels necessary to accomplish these functions. The primary question that must be answered by policymakers is, moving forward, what should Rhode Island's overarching, strategic policy be towards health reform and what role should HSRI play in implementing that strategic policy direction?

To provide context to this forthcoming decision-making process, this RIPEC brief offers a variety of related background information on HSRI:

- This brief reports on current HSRI enrollment demographics, which deliver insight into utilization of the exchange in the individual and Small Business Health Options (SHOP) marketplaces. HSRI's demographic reporting demonstrates that current enrollment totals in the individual market are approximately 39.3 percent of the estimated 67,900 covered lives who could ultimately purchase coverage through HSRI. This demographic reporting also illustrates that over half of covered lives in the individual market are over the age of 45.
- This brief also discusses background associated with the development of HSRI's broad functions or goals. This section is intended to demonstrate that there are multiple approaches to the intended outcomes of HSRI, and that HSRI's broad goals or functions have never been formally adopted or agreed to by Rhode Island's General Assembly, except by reference to the policy goals of the statutory provisions that predate HSRI and form the basis of the Executive Order.
- This publication also reviews the components of HSRI's proposed operating budget. This information sheds light on relative expenditure levels HSRI deems necessary to fulfill its varied functions, and provides insight into the type of

¹ Including RIGL 42-12.3-2, 42-14.5-2, 23-17.13-3, 42-7.2-2 and 42-62-16 et seq.

² "Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, December 6, 2013.

funding that might be required by non-federal sources in 2015. The following section of the report focuses on funding mechanisms needed to either sustain HSRI as a state-based exchange, or to pursue other options, including transitioning to the federally-facilitated health insurance marketplace (FFM). A comparative analysis of other states' decisions regarding state exchange funding is also provided.

The report concludes with RIPEC comments, which urge the development of a process to build broader stakeholder consensus around the goals of HSRI, including the incorporation of HSRI functions into the Rhode Island General Laws.

Exchange Overview

The Patient Protection and Affordable Care Act (ACA), signed by President Obama in March 2010, contained a variety of policy mandates that continue to impact Rhode Island. The first title of the Act, which articulates individual and group market health insurance reforms, calls upon states to participate in health insurance marketplaces. The Act and its accompanying regulations provide each state with the flexibility to design the operation of their marketplace, to “best meet the needs of its population.”³ Specifically, states were provided the option of operating a state-based exchange, or marketplace, or joining the Federally-Facilitated Marketplace (FFM), operated by the U.S. Department of Health and Human Services (HHS). Following the enactment of the ACA, states were provided variations of these options, including the option of pursuing a Partnership Marketplace, in which the state administers and operates activities associated with consumer assistance while relying on the FFM for all other functions of the exchange. The Act’s regulations required HHS to consider states’ application for marketplace design by June 15, 2014.

Recent Implementation

On September 19, 2011, Governor Chafee signed Executive Order 11-09, which established Rhode Island’s health benefits exchange as a division within the Executive Department. On July 5, 2012, Governor Lincoln D. Chafee sent a declaration letter to Secretary Kathleen Sebelius of HHS declaring Rhode Island’s intent to operate a state-based exchange. On December 12, 2012, Rhode Island submitted its application to HHS, and on December 20, 2012, Secretary Sebelius responded with conditional approval to establish a state-based exchange. In July 2013, Governor Chafee announced that Rhode Island’s exchange would be called HealthSource RI (HSRI). Rhode Island opened its online marketplace on October 1, 2013, with coverage effective January 1, 2014. As of August 2, 2014, HSRI had registered 26,686 enrollments in its Individual Market.

Rhode Island’s exchange, HSRI, continues to be funded by federal sources. As of May 2014, Rhode Island had been provided with a total of \$140.5 million in federal funds for the construction and operation of HSRI. Initially, Rhode Island had through December 31, 2014 to allocate this federal funding, as beginning on January 1, 2015, the ACA requires state-based health benefit exchanges to become financially self-sustained. However, as of July 2014, Rhode Island was one of four states with state-based exchanges that applied to continue spending federal revenue into 2015. Long-term funding sources beyond FY 2015 remain unknown, as there is no long-term financial sustainability plan for HSRI that has been formally presented to and accepted by the General Assembly as part of the state budget.

In addition to uncertainty related to HSRI’s long-term funding source, recent federal court decisions highlighted viability concerns associated with the FFM. In July 2014, two different U.S. Circuit Courts of Appeals issued conflicting rulings on the income tax credit provided by the Affordable Care Act. In a 2-1 decision in *Halbig v. Burwell*, the D.C. Court of Appeals ruled that ACA subsidies are only available to states that have established their own exchanges, and not to those states participating in the FFM.

³ “Blueprint for Approval of Affordable Health Insurance Marketplaces,” U.S. Department of Health and Human Services. March 7, 2014.

Alternatively, in *King v. Burwell*, the Fourth Circuit Court of Appeals unanimously upheld the Internal Revenue Service's interpretation of the ACA, ruling that subsidies are available to enrollees through both state and federally run exchanges. While the rulings have no immediate effect on exchange subsidies, their conflicting nature suggests the case could be heard in the Supreme Court, which could potentially rule on the nature of the ACA's subsidies—a fundamental component of the development of health insurance marketplaces. Because Rhode Island currently has a state operated exchange, Rhode Islanders will be able to continue to access federal subsidies for the purchase of health insurance regardless of which Court of Appeals decision the Supreme Court agrees with. However, the importance to Rhode Islanders of having a state operated exchange would be elevated should the Supreme Court adopt the D.C. Circuit Court ruling in *Halbig v. Burwell*.

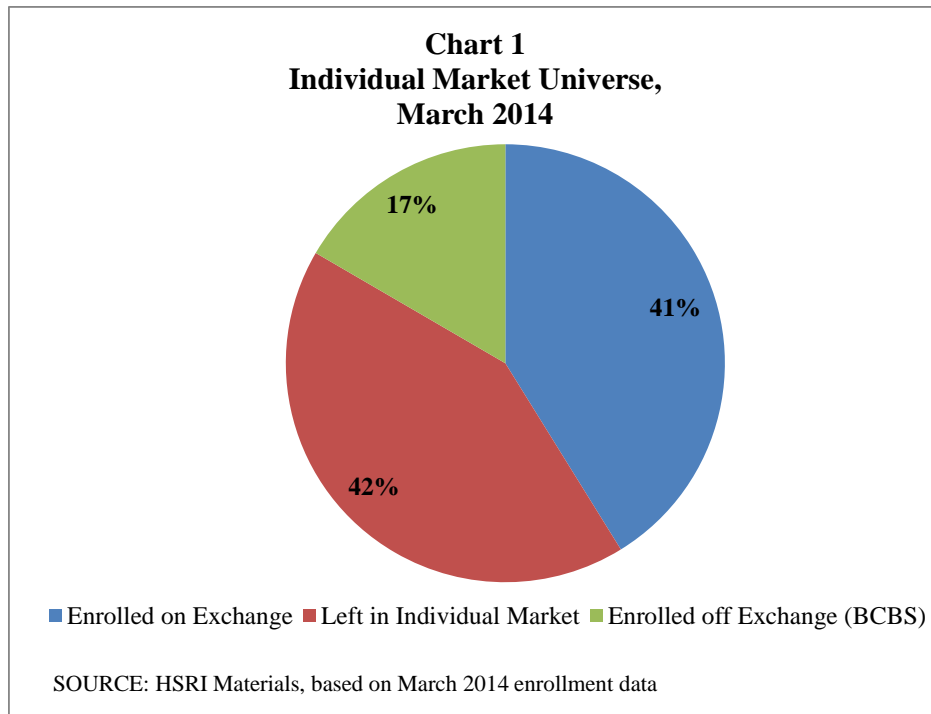
The implementation of health benefit exchanges at the state and federal level has been met with multiple obstacles, and has resulted in changes to states' initial exchange design. For example, technical malfunctions and cost considerations have prompted states including Oregon, and Nevada to take steps to close their state-based health exchanges and to consider defaulting to the federally facilitated marketplace (FFM). HSRI has largely avoided the difficulties with information technology that have afflicted other states' exchanges, however, it has yet to build a policy consensus for a long-term source of funding for HSRI operations. For this and other reasons, some stakeholders have called into question the future of Rhode Island's state based exchange. Specifically, legislation considered in the 2014 session of the General Assembly (House Bill 7817, introduced by Representative Morgan) would have directed the Governor to transfer the management and operation of HSRI to the federal government. Other briefings to the General Assembly, such as the House Fiscal Advisory Staff's May 28th presentation to the House Finance Committee, or the Senate Fiscal Office's 2014 Special Report on HSRI, suggest that there are key unresolved issues regarding HSRI's functionality and cost. These factors must all be considered as part of HSRI's forthcoming legislative policy development.

Current Enrollment Demographics

As of August 2, 2014, HSRI maintains 44 weeks of aggregated enrollment data, which describes HSRI's two main markets: Individual and SHOP (Small Business Health Options).

Individual Market

As of August 2, 2014, there were 26,686 covered lives enrolled in HSRI's individual market. The current enrollee total represents approximately 39.3 percent of the estimated 67,900 covered lives represented in the state's individual market, or universe. According to March 2014 HSRI enrollment estimates for the entire individual market universe, the remaining universe is represented by those who are unenrolled, or left in the individual market, and those who are enrolled in insurance separately from HSRI (see Chart 1).



There are more female covered lives in the individual market than males (53.2 percent versus 46.8 percent, respectively). Over half of the enrollees (51.3 percent) are over the age of 45. More specifically, approximately one third of all enrollees (28.3 percent) are ages 55 and over. Of those enrollees under 45, 17.0 percent fall within the 26-34 year age bracket. Only 4.5 percent of exchange enrollees are under 18 years.

In terms of carrier selection, most enrollees chose a Blue Cross Blue Shield Plan, as opposed to a Neighborhood Health Plan (97.0 versus 3.0 percent of enrollees, respectively). Of the four federal plan categories, or “metal,” over half of the enrollees chose silver plans (62.0 percent).⁴ Bronze plans were the second most popular (22.0 percent), followed by Gold (15.0 percent). In terms of specific plan type, over half chose the Blue Solutions for HSA Direct plan (57.0 percent). The VantageBlue Select RI plan was the second most frequently chosen option (21.0 percent), followed by the VantageBlue Direct plan (19.0 percent). Only two percent of the enrollees chose the Neighborhood Health Plan of Rhode Island Value Plan.

SHOP

Between October 1, 2013, and August 2, 2014, 262 employers enrolled in HSRI’s SHOP program—258 of which have been effectuated, or have paid. Over half, or 61.8 percent of enrolled employers were enrolled in HSRI through a broker. In this same period, there have been a total of 1,091 enrolled employees, resulting in 1,821 covered lives through SHOP. In terms of employer size, most employers enrolled in SHOP (96.5 percent) employ 25 employees or fewer. The majority of employers (61.5 percent) employ between 2 and 9 employees.

⁴ The higher proportion of Silver Plan purchasers may be related to the fact that federal subsidies for individual purchasers of health insurance are linked to the silver plan level.

When presented with the option of providing full-choice or designating a single plan for their employees, a majority of employers (64.9 percent) chose to offer their employees full-choice of the available plans. In terms of covered lives, this resulted in 75.8 percent of covered lives in the full-choice plans, versus 24.2 percent of employees being enrolled by their employer in a specific plan selected by the employer. Most employers chose Blue Cross Blue Shield plans (88.0 percent), while approximately a tenth of the employers chose United Health Care plans (and one percent chose Neighborhood Health Plan). The most popular plan types for employees within SHOP were VantageBlue (53.0 percent of effectuated employees); BlueSolutions for HAS (23.0 percent of effectuated employees); and VantageBlue Select RI (14.0 percent of effectuated employees).

Almost half (48.0 percent) of effectuated employees chose a gold plan category, and, in contrast to the individual market, only 21.0 percent chose silver plans (in the individual market, 62.0 percent of the effectuated enrollees chose silver plans). Approximately 23.0 percent of the employees effectuated in SHOP chose platinum plans, while only 8.0 percent chose Bronze plans.

Background: The Development of HSRI Goals

Addressing the remaining HSRI decision-points relies upon an understanding of HSRI's intended goals or objectives. Since the ACA provided Rhode Island stakeholders flexibility in determining how the state would respond to the law's health insurance marketplace mandate, Rhode Island, through the leadership of Governor Chafee and Lt. Governor Roberts, initiated various stakeholder input processes to discuss the state's approach to this mandate. To better understand these stakeholder processes, RIPEC reviewed the findings and content of materials from: the HealthyRI National Health Reform Implementation Task Force (2010); the Rhode Island Healthcare Reform Commission (2011); Governor Chafee's Executive Order 11-09 (2011); the Rhode Island Health Benefits Exchange Strategic Plan as recommended by the Governor's Advisory Board (2012); the HSRI Baseline Report for its Evaluation Plan (2014); and more recent statements and testimony offered by HSRI and related stakeholders in interviews and hearings. The study of these documents and processes provides a comprehensive overview of goals HSRI aimed to accomplish as a state-based exchange.

HealthyRI National Health Reform Implementation Task Force

In May 2010, Lt. Governor Elizabeth Roberts unveiled the formation of a new task force, the Healthy RI Implementation Task Force, which was aimed at ensuring that Rhode Island was prepared to implement the ACA. The Task Force met from June 2010 through September 2010, and concluded with a report, which outlined three "critical state-level decisions" Rhode Island has to make regarding the implementation of the ACA: 1) improving commercial insurance for Rhode Islanders; 2) providing all Rhode Islanders with affordable health insurance coverage; and 3) developing a new healthcare payment and delivery system in the state. The Task Force resulted in seven work groups, which focused on various components of these three decisions. One work group specifically focused on the design of the health insurance exchange that Rhode Island was considering building.

This work group concluded that if RI was to develop a state-based exchange in compliance with ACA, it must accomplish the following three requirements (see Figure 1): facilitate subsidized coverage (between 133 and 400 percent of the federal poverty

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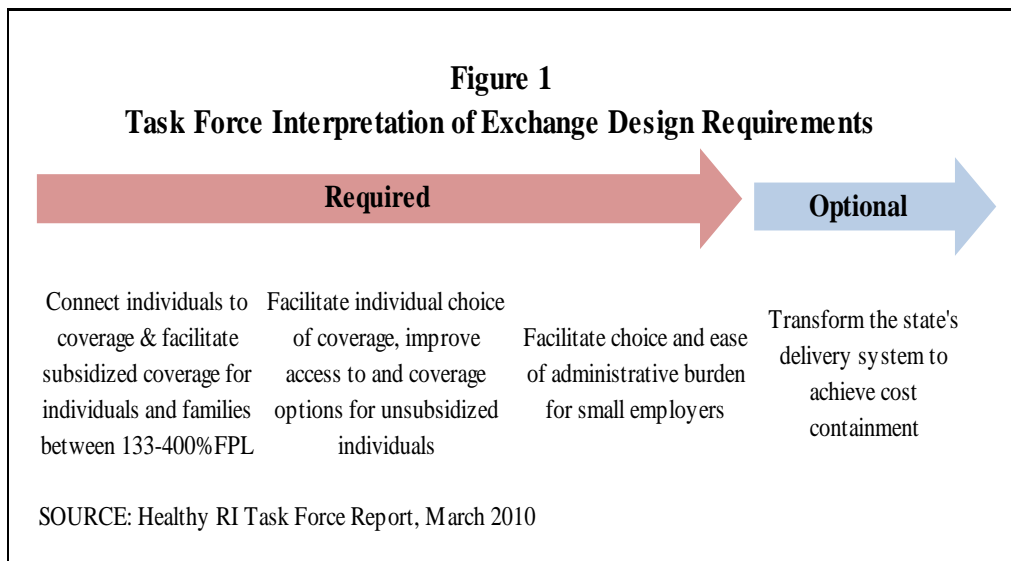
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level); facilitate individual choice of coverage and improve access to and coverage options for unsubsidized individuals; and facilitate choice and easier administration for small employers. In addition to these three requirements, the work group considered whether Rhode Island’s exchange should be a vehicle for cost containment.

This work group’s report concluded that there “was no consensus on any one strategy” regarding cost containment; however, there was consensus that efforts to contain cost ought to focus on “underlying cost of care, and delivery system reform, and not on insurance regulation and administrative cost.” Specifically, the work group concluded that there were three main options a state-based exchange would have to pursue cost containment:

- Using the power of the exchange as a purchaser to set payment models and plan design requirements in contracts with the carriers who will sell through the exchange;
- Providing the exchange regulatory authority over all provider contracts (setting standards for and/or approving all provider contracts); and
- Using the exchange to support individual purchasing, which aims to enable individuals to make more cost effective choices.

The work of the Healthy RI Task Force then informed the work of the Rhode Island Healthcare Reform Commission, which was created by Governor Chafee’s 2011 Executive Order (11-04).



Rhode Island Healthcare Reform Commission

This Commission also split up into smaller, subject-based work groups, one of which focused on the health benefit exchange provision of reform. According to its May 2011 charter, the exchange work group was intended to provide a forum to “test ideas and to determine the best vision, strategy, and business model for Rhode Island’s exchange.” A January 2012 presentation by this work group laid out a series of Rhode Island exchange policy goals: improve the health of Rhode Islanders; achieve near universal coverage; impact health insurance cost trends; impact healthcare delivery system improvement; and add value to small employer health insurance purchasing.

2011 Executive Order 11-09

In September 2011, Governor Chafee signed Executive Order 11-09, which established Rhode Island's health benefits exchange. The Order specifically listed four purposes for the creation of the exchange, including: providing near-universal health insurance coverage; organizing a transparent marketplace to help consumers and small businesses shop for, select, and enroll in affordable, high-quality, private health insurance products from a selection of easily comparable choices; providing one-stop shopping by helping eligible individuals enroll in qualified health plans offered through the exchange or coverage through other federal or state healthcare programs; and enabling eligible individuals and small businesses to receive premium tax credits and/or cost-sharing reductions. The executive order also lists out specific advantages of operating a state-based exchange:

- Maintaining state regulatory authority over the commercial health insurance market;
- Consistency and alignment of rules and regulations across health insurance markets both inside and outside the Exchange to minimize risk selection against the Exchange;
- Greater coordination of benefits and eligibility across health insurance coverage programs;
- Greater coordination and integration of eligibility determinations and enrollment with the State Medicaid program;
- Potential for promotion and alignment of state health delivery system reform strategies and priorities through the Exchange;
- Greater adaptability to changes in the local insurance and provider markets;
- Development of cooperative working relationships with insurers, brokers, agents, and other business partners; and
- Accountability to the citizens of Rhode Island.

Exchange Advisory Board and Baseline Evaluation Plan Report

In 2012, the Rhode Island Health Benefits Exchange Advisory Board to the Governor also articulated a strategic plan (2012-2015) for Rhode Island's health benefits exchange, which included five exchange goals. These goals were later incorporated into HSRI's Baseline Report for its Evaluation Plan, and include:

- Improving the health of Rhode Islanders;
- Achieving near universal coverage;
- Favorably impacting health insurance cost trends;
- Favorably impacting healthcare delivery system effectiveness and efficiency; and
- Adding value to employer health insurance purchasing.

Public Settings and Testimony

Additionally, since 2011, HealthSource RI staff has discussed HSRI's intended outcomes and goals in various public affairs settings, including legislative committee hearings. A review of these public statements from HSRI officials suggest that HSRI is broadly focused on improving consumer access; lowering overall healthcare costs; and enhancing the state health system's quality. Specific opportunities mentioned publicly by HSRI and related state officials include the opportunity for HSRI to:

- Provide increased consumer accessibility and choice;
- Improve small businesses' health insurance cost predictability through HSRI's SHOP program;
- Leverage millions of dollars in federal investment in Rhode Island's economy;
- Lower healthcare costs through more nimble and flexible price negotiating with insurance companies; and
- Provide new and innovative health products or plans.

Goal Development Summary

As this review illustrates, there are varied assessments of the goals Rhode Island's state-based exchange ought to be pursuing. An outline of these previously articulated goals provides a baseline for assessing the functions of HSRI, and whether these functions are aligned with HSRI's strategic direction. This baseline also serves as a starting point for discussion as to whether these goals are shared by other stakeholders involved in key decisions about exchange sustainability.

HSRI's Budget

There are currently two main sources of information that provide context related to HSRI's future costs: March 2014 HSRI's operating budget testimony in the House Finance Committee; and a HSRI publication that differentiates the estimated costs of various exchange functions, under two funding scenarios. These sources provide insight into the level of annual funding that may be necessary to maintain HSRI as a state-based exchange moving forward.

HSRI Operating Budget

In March 2014, HSRI presented a financial update to the House Finance Committee. This presentation included specific information about federal grants awarded to HSRI. It also provided an overview of the post-build operating budget requested by HSRI (see Table 1). This presentation is the most recent data available on HSRI's proposed annual budget, which is anticipated to total \$23.9 million annually.

- The largest proportion of the \$23.9 million proposed annual HSRI budget is the \$5.8 million allocated for the Unified Health Infrastructure Project (UHIP) tax credit and health plan enrollment system maintenance and operations. Approximately 79.0 percent of this category is for the system maintenance and operations of the UHIP system (\$4.6 million).
- Data, analytics, research and reporting accounted for \$4.2 million, or 17.8 percent of the proposed post-build budget. The largest component of this category was \$1.8 million for analysis and reporting resources, followed by \$1.0 million for technical data hosting and licensing fees, as well as product development and marketing. HSRI also budgeted \$0.5 million in this category for research, surveys and publishing.
- The third largest category of spending is personnel, which totals \$3.95 million or 16.6 percent of total operations. It contains allocations for salary and benefits (\$3.3 million), and interdepartmental staffing agreements (\$0.7 million) with the Department of Health, Office of the Lt. Governor, Office of the Health Insurance Commissioner, and the Executive Office of Health and Human Services.

- Contact center maintenance and operations accounts for 15.3 percent, or \$3.7 million of the HSRI post-build budget. This category includes \$2.5 million for customer service center staffing and support, and \$1.1 million for broker and small business support.
- The sales, marketing, outreach, education, and enrollment category in this post-build budget totals \$3.0 million, or 12.4 percent of total operations. The largest expenditure component of this category is a \$1.6 million allocation for advertisement and media.
- Approximately \$2.0 million (8.3 percent of overall costs) was allocated for administrative and infrastructure expenses, \$1.4 million of which is for facility, general and administrative costs.
- Actuarial, advisory, and legal support, accounts for \$1.3 million, or 5.4 percent of the post-build budget. This category includes qualified health plan certification support (\$0.5 million), qualified health plan certification actuarial support (\$0.5 million), and external legal support (\$0.3 million).

Table 1
HSRI Post-Build Operating Budget, March 2014

Category	Dollars (millions)	% of Total
Personnel	\$4.0	16.6%
Sales, Marketing, Education, Outreach & Enrollment	3.0	12.4%
Data, Analytics, Research & Reporting	4.2	17.8%
Actuarial, Advisory, & Legal Support	1.3	5.4%
Contact Center Maintenance and Operations	3.7	15.3%
UHIP Tax Credit & Health Plan Enrollment	5.8	24.4%
System Maintenance and Operations	2.0	8.3%
Total	\$23.9	100.0%

SOURCE: HSRI Materials

Exchange Function	Cost in a reduced- function exchange model (\$17,000,000)	Cost in a fully- function exchange model (\$23,892,740)	Difference
Improving RI Business Climate & Attracting New Business	\$0.5	\$0.5	\$0.0
Data & Analytics – Delivery System Reform, Cost, Quality, Transparency & Affordability	1.8	2.7	\$0.9
Basic Data Reporting	1.5	2.0	\$0.5
Enhanced Plan Provider Collaboration*	1.0	1.25	\$0.3
Small Business Sales	N/A	1.5	N/A
Marketing	N/A	1	N/A
Consumer Tools**	2.5	2.5	\$0.0
Premium Billing	N/A	1	N/A
Notices/Appeals	0.5	0.5	\$0.0
Comprehensive Call Center/Walk-in	N/A	0.75	N/A
Basic Call Center	1.7	1.7	\$0.0
Enrollment Application***	4.5	4.5	\$0.0
Personnel	3.0	4.0	\$1.0
Total	\$17.0	\$23.9	\$6.9

Note: N/A indicates that this function is not included in the reduced-function model

* "Enhanced plan provider collaboration" budget subtotal includes two other HSRI functions: increased carrier competition and lower barrier to entry; and innovative plan designs.

** "Consumer tools" budget subtotal includes one other HSRI function: small business full employee choice.

*** "Enrollment Application" budget subtotal includes one other HSRI function: eligibility determination system.

SOURCE: HealthSource Rhode Island, October 2014

Exchange Functionality Comparison

HSRI has provided RIPEC with a list of HSRI functions, and the estimated cost of these functions under both full-functioning exchange and reduced-function exchange scenarios (see Table 2 and Appendix A for the source document). This information also provides insight into which of HSRI's current functions are equivalent to the functions of the FFM, (and, therefore, which HSRI functions are supplemental to the FFM).

As demonstrated by Table 2, the fully-functional exchange model includes functions (i.e. small business sales; marketing; premium billing; and a comprehensive call/walk-in center) that are not present in HSRI's reduced-function exchange scenario. Also of note

Table 3
Basic Exchange Functions
(Functions equivalent to those of FFM)

Exchange Function	Cost in a reduced- function exchange model (\$17,000,000)	Cost in a fully- function exchange model (\$23,892,740)
Notices / Appeals	\$0.5	\$0.5
Basic Call Center	1.7	1.7
Enrollment Application*	4.5	4.5
Total	\$6.7	\$6.7

* "Enrollment Application" budget subtotal includes one other HSRI function: eligibility determination system.

SOURCE: HealthSource Rhode Island, October 2014

is the higher price structure for some functions in the fully-functional exchange (data and analytics and personnel are functions with the largest price differential between scenarios).

Table 3 outlines the functions that HSRI estimates are most similar to the functions offered under the FFM. The identification of these HSRI functions, and their related price, for the first time, allows the public to identify the components of HSRI (in both the reduced-function and fully-functional models) that are supplemental to the basic marketplace requirements fulfilled by the FFM.

FY 2015 HSRI Budget Submission and FY 2015 Budget as Enacted

While the post-build \$23.9 million budget for beyond FY 2015 has not yet been submitted formally as part of any budget process, HSRI did submit a formal budget request in September 2013, which outlined its proposed FY 2015 constrained budget and personnel supplement. This budget request did not contain a general revenue request for FY 2015, but it does shed light on proposed FY 2015 expenditures by category, even if these proposed expenditures are funded through federal funds (see Appendix B for details).

Ultimately, the FY 2015 budget as enacted included a 10.0 percent reduction in proposed HSRI expenditures (\$23.4 million in expenditures, as opposed to the \$25.8 million requested). Also, though HSRI asked for 27 total FTE positions (12 of which were new), the Governor's recommended budget included 25 FTE positions (10 of which were new), and the General Assembly's FY 2015 budget as enacted included 15 FTE positions. The FY 2016 Budget Request for HSRI has not yet been made publically available.

Modeling Funding Options

As required by the U.S. Department of Health and Human Services (HHS) each state with a state-based exchange is required to submit a plan to HHS that demonstrates how its exchange will be financially sustainable. Rhode Island has not yet submitted this plan to HHS.

There are multiple policy options available to stakeholders developing HSRI's sustainability plan. Existing analysis on these options currently falls into two main categories: funding options that aim to maintain HSRI as a functioning, state-based exchange; and those options that transition Rhode Island's exchange to the national marketplace, or FFM. However, as highlighted, these estimates do not provide an entire range of options Rhode Island has to consider. For example, Rhode Island could also pursue modeling costs and benefits associated with joining a regional marketplace. Regardless, these examples provide insight into the level of analysis that has occurred to date, and point to the types of data sources that would be necessary to be more predictive about financial sustainability.

Modeling the Costs of Maintaining a State-based Exchange

In July 2014, HSRI consultants presented material to the HSRI Advisory Board on potential options for a sustainable funding mechanism to maintain Rhode Island's state-based health insurance exchange. The presentation outlined the level of assessments that would be necessary to raise enough revenue to cover HSRI's projected 2016 operating costs of \$23.9 million. This model aims to answer the question "on how many individuals, and, at what rate, would assessments need to be levied to raise \$23.9 million?" Specifically, the modeling presented to the Board included five scenarios of assessments (see Table 4):

- On exchange enrollment only⁵;
- On the entire market of fully insured individuals, and small and large group markets—not including the self-insured market;
- On the entire market of fully insured individuals, small and large group, and the self-insured market;
- On the entire market of fully insured individuals, small and large group, the self-insured market, and the state's Employer Account; and
- On the entire market of fully insured individuals, small and large group, the self-insured market, the state's Employer Account, and total Medicaid spending.

⁵ This includes an increase in the small group definition to 100 FTE's.

Table 4
2016 HSRI Estimated Assessments*

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Definition	Exchange enrollment only	Fully insured individual, small, and large group	Scenario 2 + self-insured	Scenario 3+RI state employer account	Scenario 4 + Medicaid spending
Revenue Base**	\$447,088,431	\$903,611,442	\$1,782,569,735	\$2,016,809,790	\$3,918,757,488
Required Assessment	5.34%	2.64%	1.34%	1.18%	0.61%

*Data reflects 2014 HSRI rates

**Base reflects HSRI projected 2016 operating costs

SOURCE: HealthSource RI Advisory Board Materials

There are several key assumptions in the calculations for Scenario 1 in this model. First, the assumed per-member-per-month premium for scenario one is \$494.90 for the SHOP marketplace, and \$410.45 for the individual marketplace.⁶ Scenario 1 also assumes 2016 SHOP enrollment to be 52,850, and 2016 individual enrollment to be 41,093. As of August 2, 2014, there were 1,821 covered lives in SHOP and 26,686 covered lives enrolled in HSRI's individual market.

While the modeling methodology of Scenarios 1-5 is partially explained by these assumptions, HSRI confirmed that the primary data for Scenarios 2-5 was from publicly available sources trended to 2016. It is likely that the population for: Scenario 2 is approximately 306,420 covered lives⁷; Scenario 3 is 552, 118 covered lives⁸; Scenario 4 is 590,868 covered lives⁹; and Scenario 5 is 790,868 covered lives¹⁰. However, it is important to note that the HSRI consultant's model references Medicaid expenditures and not Medicaid enrollment, or covered lives in Scenario 5.

The Rhode Island Senate Fiscal Office (SFO) also prepared a model of possible assessments required to fund SFO's definition of a "neutral scenario," of HSRI expenditures, or \$21.0 million. This model relies upon HSRI's assumption of 81,000 HSRI enrollees in the private insurance marketplace to determine what assessment would need to be levied to raise enough revenue to fund HSRI at the \$21.0 million level. According to this model, if just the 81,000 anticipated HSRI enrollees in the private insurance marketplace were assessed, the fee would be \$259.26 per-member-per-year, or \$21.60 per-member-per-month. Alternatively, if all HSRI enrollees, including Medicaid enrollees, were assessed (a total of 273,000 enrollees), the annual assessment would be \$76.92 per-year, or \$6.41 per-month. The annual assessment on all insured statewide (750,963 enrollees) would be \$27.96, or \$2.33 monthly.

Using the SFO model as a framework, it is also possible to substitute HSRI's 81,000 enrollee prediction for current HSRI enrollment figures. As of August 2, 2014, there were

⁶ While these are projected for 2016, these rates are based on 2014.

⁷ Rhode Island Office of the Health Insurance Commissioner, Commercial Market Enrollment as of April 30, 2014

⁸ Ibid.

⁹ Rhode Island Office of Human Resources

¹⁰ Rhode Island Executive Office of Health and Human Services

1,821 covered lives in SHOP and 26,686 covered lives enrolled in HSRI's individual market—a total of 28,507 covered lives. At this level of covered lives enrolled in HSRI, the annual per-member-per-year fee would be \$736.66 (or \$61.38 monthly).

Modeling the Cost of Alternatives

Even if stakeholders determine that the costs of maintaining HSRI as a state-based exchange are unsustainable into the future, there will be costs to alternative options. Since there have been no states to develop a regional, multi-state exchange, it is unknown what type of costs Rhode Island would face if it were, for example, to join Massachusetts and Connecticut in developing a regional, multi-state exchange. While there does not appear to be publicly available analyses on the potential for Rhode Island to join a regional exchange, other states have hired firms to model regional exchange cost implications.

For example, the State of Wyoming Department of Insurance hired a firm to review appropriate staffing models, enrollment estimation, resource and capabilities, and overall exchange functionality of potential partner states. This study found functions such as call centers, auditing/actuarial staff, legal and consulting services, and IT/website technologies were areas that had potential for “moderate” savings.” Alternatively, the study found there was little to no potential for savings in sharing enrollment and eligibility systems, marketing, navigators, or billing engines.

Table 5		
Methodology for FFM Fee Assessment		
3.5% x Avg. Monthly Premium In Individual Market x 12 = Avg. Annual Charge to Join FFM	X	# Enrolled Individuals in Individual Market
		=
		Cost of Joining FFM in Individual Market
		+
3.5% x Avg. Monthly Premium In Sm. Group Market x 12 = Avg. Annual Charge to Join FFM	X	# Enrolled Individuals in Sm. Group Market
		=
		Cost of Joining FFM in Sm. Group Market
		Total Cost of Joining FFM

SOURCE: House Fiscal Advisory Staff

Similar to the uncertainty surrounding the cost implications of a regional exchange, there is uncertainty surrounding the costs associated with state-based exchanges transitioning to the FFM. Federal guidance suggests that for 2015, states that join the FFM are charged a 3.5 percent fee (of monthly premiums). The total cost of this fee equals a monthly 3.5 percent charge on the average monthly premium for both the individual and small group markets (see Table 5). According to HSRI's interpretation of federal guidance, premiums charged by carriers must be the same for the same produce inside and outside the exchange, and while the assessment only applies to businesses through the exchange, carriers will likely spread the cost of the assessment across their entire non/small group book.

It is also important to note that if Rhode Island were to transition to the FFM, there may be other costs additional to the 3.5 percent fee. First, as in the Oregon example, the state would need to determine what to do with the other, non-private insurance enrollees (i.e.

Medicaid enrollees) who registered through the HSRI platform. Oregon chose to transfer these enrollees to another state department or entity, which carried a multi-million dollar price tag.

Another cost consideration that was raised when switching FFM was discussed in May in the House Finance Committee related to the potential need of wrap-around services if HSRI were to transition to the FFM. For example, HSRI currently maintains an active, walk-in call center that provides customer service to consumers. The FFM does not operate call- or walk-in centers in states, which prompted some policymakers to suggest supplemental services to augment the federal online and telephone platforms. There are few examples of these wrap-around services in states that chose to operate in the FFM.

Lastly, another unknown of switching to the FFM relates to the potential repayment of federal grant money that has been provided to build HSRI. Rhode Island has already secured \$140.5 million in federal funding, allocated \$89.0 million, and spent \$45.8 million. Rhode Island may face some federal resistance, if it chooses to transition to the federal government, as states that have transitioned to the FFM have been asked to testify before the House Oversight Committee (HOC) and the Government Accountability Office (GOA).

Comparative Analysis: State Sustainability Plans

Of the states that established their health benefits exchanges through executive order (Kentucky, New York, and Rhode Island), none have adopted a sustainable financing plan. In contrast, many of the states that established their health exchanges through legislation included funding mechanisms to finance operations. Of the states that have decided to continue to operate their state-based exchanges, many have created and are moving forward with sustainability plans established through their respective legislatures. This section discusses the established sustainability plans for some state-based exchanges.

Some of the states with established sustainability plans opted to impose a carrier assessment - charging fees for plans on and off of the exchange (limited to the carriers offering insurance on the exchange), while others chose to implement a market-wide assessment that applies to all plans offered by all carriers, while others relied on user fees and general revenue funds.

After 2014, California plans to finance its exchange, Covered California, through fees paid by health plans and insurers participating in the exchange. In November 2012, Covered California published its Financial Sustainability Plan, which proposed levels of participation fees in the individual and SHOP marketplace. The plan is to bill issuers monthly for the payment of the fee, which is to be based on the monthly enrollment totals for those enrolled in QHPs in and outside of Covered California. In the individual market in 2014, the assessment on participation in the exchange is 3.0 percent of the average premium across all plans sold on the exchange. In a May 2014 Covered California Board meeting, the Board projected that assessments would be maintained at \$13.95 per-member-per-month in 2015 and 2016. Also, the fee for those enrolled in plans off the exchange is set at half of the per-member-per-month fee that is charged for those enrolled in the exchange.

Covered California's proposed participation fee for SHOP is 4.0 percent of premiums paid to support operational costs, plus an additional percentage fee to support agent commissions. Also, on those qualified health plans sold to small businesses outside of Covered California, there would be a 2.0 percent fee on premiums paid. In May 2014, the Covered California Board adopted 2015 per-member-per-month fees of \$18.60 for SHOP health plans with or without embedded dental coverage. The Board intends to review the assessment annually and adjust it based on the funding needs of the exchange and the amount of revenue being generated.

Colorado has outlined a 3-pronged approach to funding Connect for Health Colorado: early revenue (federal grants, high risk pool reserves, and a broad market assessment); enrollment-based revenues; and other opportunities. In terms of early revenue, and specifically, the broad market assessment, the state set a \$1.80 per-policy-per-month maximum assessment on all insurance carriers in both the small group and individual markets through 2016. However, the FY 2015 budget enacted by the Board in June 2014 reduced this maximum assessment to \$1.25 per-policy-per-month. The state's enrollment based revenue fee was set at 1.4 percent of premiums in 2014, and will be set annually by Connect for Health's Board of Directors. "Other funding opportunities" mentioned include adding supplemental products to the exchange; carrier tax credit donations; website advertising; cost-sharing with other states; and foundation grants.

Connecticut's exchange, Access Health CT, is authorized by statute to "charge assessments or user fees to health carriers that are capable of offering a qualified health plan through the exchange or otherwise generate funding necessary to support the operations of the exchange."¹¹ Access Health CT had stated that assessments for carriers will be calculated as a percentage of earned premiums that carriers report for their individual and small group businesses for the previous calendar year. In May 2013, the Board of Directors of Access Health CT has approved a plan for calendar year 2014 to collect a 1.35 percent carrier assessment on total premiums collected by all insurers offering small group or individual health insurance plans. More recently, the Board has voted to approve maintaining the same assessment of 1.35 percent for calendar year 2015.

The Board of Directors of the Hawaii Health Connector chose to assess a fee on all insurance plans sold through the exchange. Beginning January 1, 2014 the Board began collecting a 2.0 percent fee on all individual health insurance plans sold through the exchange's individual market, and a 2.0 percent fee on premiums for plans sold on the SHOP portal beginning July 1, 2014. However, lower-than-expected enrollment resulted in lower-than-anticipated revenue collections. In response, Hawaii's legislature approved legislation (S 2470) in 2014 that appropriated \$1.5 million to the Hawaii Health Connector. This legislation also allows the exchange to charge assessments or user fees to participating health and dental carriers, or generate non-insurer based funding to support its operations. Moreover, the legislation requires the exchange's board to prepare and submit 2015 and 2016 reports to a legislative oversight committee with updates on the exchange's sustainability plan.

In Idaho, state legislators empowered the Board of Directors of Your Health Idaho, the state's insurance exchange, to collect monthly fees from health insurance carriers

¹¹ Section 38a-1083(c)7 of Connecticut General Statutes

participating in the exchange. The Board adopted a 1.5 percent fee assessed on all plans sold through the exchange (with an option to increase the fee after 2014) in 2013 to fund the exchange's projected operating budget. Idaho retained the 1.5 percent assessment fee on policies sold via the state's exchange for 2015.

Massachusetts is transitioning from previous health insurance programs to the Massachusetts Health Connector, or ConnectorCare, which is statutorily authorized to charge fees on all health benefit plans. Commonwealth Care, the state's previously subsidized insurance program, charges an administrative fee based on a percentage of the capitation payments, which from July through December 2014, were approximately 2.4 percent of capitation. For Commonwealth Choice, the state's unsubsidized program, the administrative fee is based on monthly premiums. However, there were no carrier administrative fees in 2014 for Commonwealth Choice (though in 2013 the Commonwealth Choice fees were 3.5 percent of premiums for non-group businesses and 2.5 percent of premiums for small group businesses).

Commonwealth Care will be phased-out by December 31, 2014, with individuals transitioning to the Health Connector. The Connector temporarily suspended charging carrier fees for calendar year 2014, but plans to reintroduce them for January 2015 and beyond. As of the May 2014 Connector Board of Directors meeting, the Connector's proposed fee structure includes: 2.5 percent on non-group and small group qualified health plans (greater than 300.0 percent of the federal poverty level); 3.0 percent fee on ConnectorCare plans; or 3.0 percent on non-group and small group qualified dental plans.

Minnesota chose to finance its exchange, MNSure, through a combination of a 1.5 percent fee (percentage of the premiums) on individual, small group, and dental plans sold through the exchange in calendar year 2014 (increasing to 3.5 percent in calendar year 2015), and an allocation of \$20.0 million from the state's general fund in FY 2014 and 2015. In May 2014, the MNSure Board approved a 3.5 percent premium withhold on QHPs for 2015, which will be used to fund the operations of the organization. Minnesota decided to base its fee on the volume of insurance premiums for plans sold through its exchange.

In 2012, a sustainability report was submitted to Washington's legislature outlining three options for funding the state's exchange into 2015. In June 2013, the Governor signed legislation which approved a 2.0 percent premium tax on all plans sold through the state's exchange. The legislation also stipulated that remaining funds needed by the exchange could be generated through an assessment on participating carriers.

Summary

The Cooperative Agreement documentation from HHS requires states to submit information related to the "long-term operational cost analysis and sustainability plan including specific activities and a timeline to assure the self-sustaining requirement of the exchange is met." As these examples illustrate, states have approached this requirement differently. HSRI has not proposed a plan or timeline for its long-term sustainability.

Transitioning to the Federally Facilitated Marketplace

Rhode Island was one of 17 states, and the District of Columbia, that chose to establish a state-based exchange under the ACA. However, now, three of these states, Oregon, Massachusetts, and Nevada recently considered transitioning to the FFM. This section will outline the factors associated with these potential moves away from state-based exchange towards the federally-operated marketplace.

Oregon

On October 1, 2013, Oregon's state marketplace opened its health benefit exchange, named Cover Oregon. The Cover Oregon nine-member Board of Directors (seven voting members, two ex-officio members) teamed with Oracle to create an online portal, spending \$255.0 million in federal grants as of June 2014. Despite the opening of the online marketplace, applicants were unable to enroll through the online portal because of continual technical glitches, leading to a paper application process that enrolled 372,618 enrollees (for private insurance and Medicaid) before the April 31, 2014 deadline. Due to the technical glitches, the enrollment period was extended for one month.

On February 10, 2014, state consultant Deloitte Consulting presented a report, "Policy Alternative Assessment Preliminary Report" to various stakeholders, which outlined four options related to Cover Oregon's future. One of these four options included a transition to the ACA's Federally Facilitated Marketplace (FFM). After receiving this report and other analyses, Cover Oregon officials determined that fixing its current system would cost \$78.0 million. Alternatively, moving operations to the federal marketplace was projected to cost the state between \$4.0-6.0 million. On April 25, 2014, the Board of Covered Oregon voted to join the FFM. Oregon was the first state-based exchange to transition control to the federally-operated exchange.

Now that Cover Oregon is transitioning to the FFM, enrollees will have to re-enroll in the federal plan. The state still anticipates spending \$35.0 million to transition Cover Oregon's technology to the Oregon Health Authority, which will take responsibility for those enrollees qualified for Medicaid (this \$35.0 million is additional to the \$4.0-6.0 million associated with moving to the FFM).

Nevada

Nevada opted to establish a state-operated health exchange when state lawmakers and Governor Brian Sandoval enacted legislation in 2011 creating the Silver State Health Insurance Exchange. This law required the creation of a ten-member board of directors (seven voting members, three ex-officio members) to oversee the exchange and an executive director to manage its day-to-day operations. In early 2012, a contract worth nearly \$72.0 million was awarded to Xerox as the result of a request for proposal application to develop the website and other information technology needed to run the exchange.

The Silver State Health Insurance Exchange website went live on October 1, 2013 in accordance with the ACA, but immediately began to suffer from repeated technological glitches. By the end of open enrollment on March 31, 2014, the exchange had enrolled just 25,899 people in new health plans compared to an initial goal of 118,000 enrollees. In response, the board of directors extended the open enrollment period until May 30,

2014. However, as of May 10, the exchange counted 35,000 enrollments. This led the board of directors to consider moving in a new direction with the exchange.

After discussions with the federal Centers for Medicare and Medicaid Services (CMS), the board of directors decided among four options to transfer back to the federally-operated exchange. Specifically, the third option involved an immediate transition to the FFM under the oversight of CMS. The deadline for choosing this option for Plan Year 2015 was set at June 30, 2014 by CMS officials. Under this option, the exchange would still retain its status as a state-based exchange and the state could continue to explore options for developing a new online marketplace and call center. The board also terminated the existing contract with Xerox.

The federal government will now assume responsibility for operating the state's online marketplace and call center, but the state will retain the ability to approve the health insurance plans that can be sold through the exchange and verifying Medicaid eligibility. The state estimates that the total cost for the transition will be up to \$20.0 million, of which Nevada will be responsible for 10.0 percent. The board of directors also voted to issue a new request for proposal seeking new software with which it can operate the online marketplace and call center in the future.

Massachusetts

Though Massachusetts officials have decided to maintain its state-based exchange, recent technical challenges almost prompted the state to use the federal system. The Massachusetts health insurance exchange, known as the Health Connector, was established in 2006 prior to enactment of the federal Affordable Care Act. The exchange, overseen by an 11-member board of directors (seven voting members, four ex-officio members) and an executive director, is responsible for managing the agency on a daily basis.

After passage of the ACA, the Health Connector was designated by Massachusetts as a State-Based Exchange under the law. However, enactment of the ACA necessitated a number of changes to the original Health Connector marketplace. To implement those changes, the state contracted with CGI, the same company originally responsible for creating the federal Healthcare.gov marketplace. The modified marketplace created by CGI was beset by technical malfunctions and other problems immediately after it began operating in late 2013. After continued problems, the board of directors of the Health Connector voted to terminate the agreement with CGI in March 2014.

After terminating the existing agreement with CGI, the state proceeded with a two-path process. The state entered into a contract with hCentive to develop a new online marketplace and call center that can be utilized for plan year 2015. At the same time, the state is beginning to transition to the FFM. Originally, policymakers decided that if the marketplace being developed by hCentive is not ready in time for the open enrollment period that begins in November 2014, the state will use the federal system for one year, and then transition back to a completed state-run exchange the following year. However, in early August 2014, the U.S. Centers for Medicare and Medicaid Services provided confidence in the new hCentive system, prompting Massachusetts officials to decide to continue running its own state-based health insurance exchange.

Comments

The first title of the ACA, which articulates individual and group market health insurance reforms, calls upon states to participate in health insurance marketplaces. The ACA and its subsequent regulations provided states the flexibility to determine whether they would operate a state-based exchange, join the Federally-Facilitated Marketplace (FFM) operated by the U.S. Department of Health and Human Services (HHS), or form regional or partnership marketplaces. Rhode Island, through executive order, created a state-based health insurance exchange, which has remained a functional operation. However, long-term funding sources beyond FY 2015 remain unknown, as there is no long-term HSRI financial sustainability plan. This ambiguity has driven exploration of alternative options to HSRI, such as transitioning to the FFM or pursuing a regional exchange. Since all alternatives offer varying functions and costs, this report begins to outline considerations associated with this decision.

Unknowns about HSRI's future, specifically regarding long-term funding, highlight a fundamental shortcoming in Rhode Island's approach to healthcare policy. Through the development of HSRI, the state has created a government entity tasked with accomplishing a set of healthcare reform goals that went beyond federal requirements, without a long-term, sustainable funding plan. Specifically, the founding entities that developed the functions of HSRI opted to position Rhode Island's exchange not only as a mechanism to connect individuals to coverage, and facilitate choice of coverage for individuals and small employers (functions required by ACA); rather, HSRI's founders opted to create a state-based exchange that aims to transform the way Rhode Island's healthcare delivery system is structured with the goal of containing healthcare costs.

There has been no executive and legislative consensus on its breadth of goals; the cost of accomplishing these goals; or a plan for funding the execution of these functions. More broadly, there has been no strategic, consensus-driven discussion of a long-term healthcare reform vision for Rhode Island. This type of vision, would, for example, discuss the ways in which HSRI fits within Rhode Island's broader healthcare spending and regulatory programs. Since HSRI's sole reliance on federal funding will eventually end, and various long-term funding options for HSRI are being considered by HSRI's Advisory Board, it will be necessary to pursue a process to determine Rhode Island's preferred response to the ACA mandate, and ultimately incorporate this response into state law. This will help ensure that there is broader stakeholder consensus on goals HSRI aims to accomplish, and, therefore, the levels at which it should be funded.

There are four main questions that need to be agreed upon as stakeholders deliberate HSRI's future:

- 1) Considering the ACA's marketplace mandate, what type of healthcare reform goals should Rhode Island pursue?
- 2) What is the best governance model to accomplish these goals?

- 3) How should this provision of services be funded?
- 4) How should this provision of services be evaluated?

Rhode Island has effectively implemented an exchange. However, the eventual absence of federal funding and the desire for long-term sustainability require stakeholders to pause and consider the path forward. Deliberation on this issue should focus on two tracks: the process moving forward if Rhode Island is to maintain a state-based exchange; and a process for examining whether Rhode Island should opt-out of the state-based exchange model and pursue an alternative model, such as joining the FFM or pursuing a regional exchange. The following sections provide information on the implementation and consideration of these issues.

Questions 1 and 2: Considering the ACA's marketplace mandate, what type of healthcare reform goals should Rhode Island pursue, and what is the best governance model to accomplish these goals?

As this report outlines, there are several functions that could be accomplished through either a state based-exchange or alternative models. In relation to the state-based exchange model, RIPEC has summarized some goals and functions articulated by HSRI, including issues for consideration.

➤ **HSRI Goal: Improving Consumer Choice and Accessibility**

HealthSource RI officials have stated the tools created through HSRI are intended to provide a more transparent way of educating consumers on their health insurance choices. The five-step HSRI enrollment process (accessing HSRI via phone, the website, or in person; completing information on income and family composition; determining eligibility for tax credits or Medicaid; comparing health plans; and choosing a plan) is aimed at providing one-stop health insurance shopping. Specifically, step four of this process, (the comparison of insurance plans through HSRI's rate sheet publications) is intended to improve consumer education of health insurance options.

Also, the Small Business Health Options (SHOP) marketplace is aimed at mitigating the impact of increasing health coverage costs on small businesses by combining the buying power of eligible Rhode Island small employers. "Full Employee Choice," an option within the SHOP marketplace, allows small businesses or non-profit organizations to choose to allow employees of the same firm to pick different health insurance plans (as opposed to one plan for the entire firm). Since the ACA only requires that employers in the SHOP marketplace pick at least one plan in each of the tiers (bronze, silver, gold or platinum), providing "Full Employee Choice," as Rhode Island has, goes beyond the requirements of the ACA.

➤ *Considerations*

HSRI's marketplace design, infrastructure, and publications are aimed at improving the educational process associated with purchasing health insurance. Moving forward, whether enhanced consumer choice results in positive differences in health quality and cost should be monitored. Consideration should also be granted to what the costs of these one-stop insurance shopping features are, as a proportion of HSRI's overall costs, and whether the magnitude of these changes in consumer behavior merits the public investment.

➤ **HSRI Goal: Small Business Health Insurance Cost Predictability**

The establishment of SHOP marketplaces nationwide was designed to improve access to coverage for small employers. SHOP was also intended to improve the predictability of health insurance costs, as small employers' risk pools are more susceptible to changes in employee health circumstances. A key feature of Rhode Island's SHOP program is intended to allow participating employers to set a predictable contribution towards their employees' health insurance coverage while also offering choices in various (or all) plan tiers. Specifically, in Rhode Island's SHOP design, the employee contribution is based on the cost difference between the plan the employee chooses, and the reference plan designated by the employer.

The unique aspect of Rhode Island's SHOP program relates to its methodology for addressing federal regulations associated with insurance rating factors (i.e. age, geography, tobacco use, and family size). Federal regulations allow small group premiums to be adjusted by rating factors, which could lead to scenarios in which individual employees have different ratings. Rhode Island, like Oregon, instead developed a methodology that provides an average, or composite rate, in which the same insurance ratings are applied to every employee. This composite approach is intended to help employers' cost predictability when employees join or leave the company.¹²

July 2014 enrollment data shows that 189 employers were enrolled in Rhode Island's SHOP marketplace, 70.9 percent of which enrolled in Full Employee Choice. Of this total, about half of those employees chose their employers' reference plan, whereas approximately 21.0 percent of employees bought a more expensive insurance plan, and 13.0 percent bought a less expensive plan. Overall, Rhode Island's SHOP enrollment covers over 1,321 individual lives in Full Employee Choice and 383 covered lives in SHOP's Single Plan.

¹²According to the Commonwealth Fund, New York and Vermont allow employers to contribute a set amount towards employees' selected plans regardless of age, even though these states do not offer a composite rating system.

➤ *Considerations*

As highlighted in HSRI's baseline evaluation report, it is important to monitor the participation in RI's SHOP program, particularly the number of employers statewide that participate in SHOP, as a proportion of overall eligible employers. This indicator provides better insight into the ability of participants in SHOP to leverage greater purchasing power in the overall marketplace and to stabilize SHOP's risk pool. Also, the data surrounding the types of plans selected through SHOP should continue to be monitored, as it can help assess whether Rhode Island's seemingly unique rating methodology merits the administrative complexity, and impacts Rhode Island's competitiveness. Furthermore, some states (Vermont, Massachusetts, and Washington, D.C.) have chosen to merge their SHOP marketplace with their respective exchanges' individual insurance marketplaces—the impact of which should be monitored for its potential to lower premiums in the long-term.

➤ **HSRI Goal: Leveraging Federal Investment**

Another justification for creating and maintaining Rhode Island's state-based exchange is the positive economic effects of the available federal funding for HSRI. Federal funds are scheduled to support planning, establishment, and initial operations of HSRI at least until December 21, 2014. As of late May 2014, Federal grants to the Lt. Governor's office, the Department of Business Regulations, and HSRI have totaled \$140.5 million (including a relatively new grant of \$29.0 million).

A large portion of the federal grants have gone towards Rhode Island's Unified Health Infrastructure Project (UHIP), which is an Office of Health and Human Services project that works with HSRI to provide one digital system that allows consumers to apply for benefits. It is intended to replace the existing multiple state eligibility systems, with the goal of improving data entry and verification efficiency and effectiveness. One planning document of the Executive Office of Health and Human Service projects the overall project cost for UHIP will be \$209.4 million (\$157.5 million, of which is federal funds). HSRI is responsible for approximately \$13.0 million of total project costs.¹³

➤ *Considerations*

While the federal grant infusion provided to Rhode Island for HSRI has resulted in short-term economic benefits to Rhode Island's economy (hiring of HSRI employees and consultants is one example), and has led to systemic changes to the methods and extent to which state government responds to human service eligibility requests and Medicaid coverage, the long-term sustainability of these

¹³ It is important to note that federal money for UHIP is separate from ACA funding, but both contributions are funding a jointly-linked technology project.

changes must be considered. For example, it is worth considering how HSRI and UHIP will be sustainably funded after its initial multi-agency build. Efficiencies and program integrity of the new joint-system should also be considered.

➤ **HSRI Goal: Lower Health Insurance Costs**

Another goal of HSRI is to eventually lower overall healthcare costs by increasing competition, and lowering premium rates. There has been little analysis comparing premium rates across state exchanges. However, a previous RIPEC [analysis](#) found that as of November 2013, HSRI was charging premiums that were among the lowest in New England, but offered deductibles that were among the highest in New England. Also, *The National Journal* and PricewaterhouseCoopers recently reported that of the states that have released preliminary information about insurance policy premiums, ten states will see average premium increases of less than 10.0 percent (which, they reported, is in line with national historic trends). However, it is important to note that initial rates can still change, as states can re-negotiate rates and enrollment numbers fluctuate. Regardless of the study, observing Rhode Island's premium rates over time will be critical to measuring HSRI's success.

➤ *Considerations*

If one of the goals is to reduce consumer health insurance costs, a series of questions related to HSRI's progress on this goal must be considered:

- Has HSRI identified the magnitude to which it seeks to lower costs for consumers?
- If this range or target reduction has been identified, how are HSRI's premiums currently faring against these targets? Are there other indicators of cost reduction that should be monitored?
- Are these changes to the premium structure sufficient enough to affect the healthcare cost curve in Rhode Island in the long-term?
- How do these changes to the premium structure compare to those in the private marketplace, outside of HSRI?

Lastly, stakeholders must consider the price they are collectively willing to pay for HSRI to be able to reduce health insurance costs. For example, one analysis found that in 2014, the cost of healthcare per enrollee in the private insurance component of HSRI, was \$3,697. This is the fifth-highest amount of any state-based exchange, less than Hawaii, Massachusetts, Oregon, and Vermont, and slightly higher than Minnesota and Kentucky.¹⁴ Monitoring cost per enrollee will be critical for Rhode Island moving forward, as it has the second-smallest

¹⁴ Angoff, Jay. *Cost-per-enrollee in Each State's Exchange*. Rep. Mehri & Skalet PLLC, 7 May 2014. Web. 1 Aug. 2014.

population of the state-based exchanges, and is the eighth least populous state in the U.S.

➤ **HSRI Goal: New, Innovative Products and Health System Reform**

HSRI officials have also referred to the ability of Rhode Island's state-based exchange, through greater negotiation with insurance carriers and the Office of the Health Insurance commissioner to press commercial providers to offer new and innovative health insurance products aimed at changing the healthcare delivery and payment system. For example HSRI's most recent rate sheets outline various tiered plans among the federal plan categories, which, according to HSRI, aim to incentivize improved decision-making by consumers (Blue Cross Blue Shield of Rhode Island offers tiered plans that offer different primary care copayments). Specifically, these tiered plans offer lower copayments for visits to primary care medical home (also referred to as patient centered medical homes) than consumers would have for visiting non-primary care medical homes. Other examples of delivery and payment reforms include shifting towards non-fee-for-service payments (payers reimburse for all medical service, regardless for impact on health) and value-based healthcare (using outcome data to identify best practices at lowest costs).

➤ *Considerations*

In assessing the value of HSRI's innovative plans moving forward, consideration should be granted to:

- In relation to tiered plans, the proportional number of HSRI enrollees who selected tiered, or innovative plans and whether these incentives, such as lower copayments for better usage choices, were effective in driving healthier behavior;
- How Rhode Island can best position itself, through its exchange negotiations with commercial carriers, to better leverage the federal delivery and payment system reforms driven by Medicaid and Medicare programs; and
- How the health system reforms driven through HSRI relate to, or are coordinated with health system reforms that are ongoing across Rhode Island state government.

Question 3: How should the provision of healthcare services be funded?

Regardless of the path forward, there will be costs associated with Rhode Islands compliance to the ACA's marketplace mandate. Rhode Island stakeholders must also consider the level at which a state-based exchange, or alternative options should be funded, and the long-term funding sources available. As this report outlines, there are a range of scenarios for HSRI funding (i.e. \$17.0 million versus \$23.9 million), however,

choosing a funding level requires consensus on which functions should or should not be included in a state-based exchange (see Table 2 and appendix A).

Once a funding level is decided, options for raising revenue should also be considered. For example, policymakers must determine the populations of individuals that would be affected by an assessment on premiums. Alternatively, they would need to consider the appropriateness of general revenue allocation of funds, or the other options pursued by other states (many of which are included in this report's comparative analysis). Simultaneously, stakeholders may want to weigh the costs and benefits of potential funding mechanisms for HSRI with those of transitioning to the FFM, or potentially a regionally-based exchange.

Question 4: How should the provision of healthcare services be evaluated?

Upon a decision about functions, funding levels, and funding mechanisms, consideration should be granted to how exchange effectiveness (either through state-based, regional, or federal exchange participation) should be measured. For example, HSRI currently maintains an evaluation plan aimed at measuring the success and effectiveness of its current operation. If changes are determined necessary to HSRI's current structure, or if the state decides to transition to another exchange model, what types of revisions would be required to this evaluation plan?

Conclusion

Since HealthSource Rhode Island will eventually require non-federal funding to sustain its operations, HSRI's intended functions, and exchange design options should be reviewed and agreed upon by the Governor and General Assembly. Specifically, RIPEC urges the development of a process to build broader stakeholder consensus around the goals of HSRI, including the incorporation of HSRI functions into the Rhode Island General Laws. Once there is broad acceptance of HSRI's intended functions and objectives, Rhode Island may consider the examples provided by other states' funding plans, to assist with developing and adopting a sustainable plan for addressing Rhode Island's out-year health insurance marketplace costs.

Moreover, Rhode Island stakeholders should consider how HSRI's goals fit with ongoing health reform initiatives across municipal and state government. For example, what is the connection between the reform goals of the Office of the Health Insurance Commissioner, the Executive Office of Health and Human Services, and HSRI? Also, under what circumstances should other government-sponsored health plans be purchased through the HSRI marketplace? Similarly, stakeholders must consider whether Rhode Island is best positioning itself (whether through HSRI or other government entities) to capitalize on national trends in medical service delivery and payment reforms. Without a common, coordinated strategy for how Rhode Island plans to meet the ACA health insurance marketplace requirement, and how this approach relates to ongoing health

reform initiatives across the state, Rhode Island's health reforms will fail to maximize their full potential.

For these reasons, RIPEC urges the next Governor to lead on this issue by incorporating a plan for the future of HSRI, which should include his or her position on the following:

- The proper goals and functions of HSRI;
- The costs of each of those functions;
- A recommended long-term funding and evaluation strategy for HSRI; and
- Overall recommendations related to how HSRI can be better coordinated and aligned with ongoing healthcare reform efforts.

This plan ought to be presented to the General Assembly as part of the Governor's FY 2016 budget submission, with the goal of developing consensus and a common direction on HSRI's future. Additionally, RIPEC recommends further consideration of a process moving forward that would craft an overall vision, or direction, for all state policies associated with health reform. This vision should also be incorporated to the forthcoming plan of the Economic Development Planning Council, which, effective January 1, 2015, is to convene an economic development planning council during the first year of each new or re-elected gubernatorial administration. As without this overall vision, there is potential for the duplication of effort and resources.

Appendix A



HealthSourceRI

Exchange Functionality Compare

Exchange Function	HSRI Full-Function	HSRI Reduced Function	FFM
Estimated Cost	\$23,892,740	\$17,000,000 (same costs, higher level of service)	
Improving RI Business Climate & Attracting New Business	.5	.5	
Data & Analytics – Delivery System Reform, Cost, Quality, Transparency & Affordability	2.7	1.8	
Basic Data Reporting	2.0	1.5	
Enhanced Plan Provider Collaboration	1.25	1.0	
Increased Carrier Competition / Lower Barrier to Entry	Included in 1.25	Included in above 1.0	
Innovative Plan Designs	Included in 1.25	Included in above 1.0	
Small Business Sales	1.5	x	
Marketing	1.0	x	
Consumer Tools	2.5	2.5	
Small Business Full Employee Choice	Included in above 2.5	Included in above 2.5	
Premium Billing	1.0	x	
Notices / Appeals	.5	.5	x
Comprehensive Call Center / Walk-in	.75	x	
Basic Call Center	1.70	1.7	x
Enrollment Application	4.5	4.5	x
Eligibility Determination System 10/15/2014	Included in above 4.5	Included in the above 4.5	x

Appendix B

HSRI Budget Submission, September 2013 (Federal Funds)		
Category	FY 2015 Constrained Budget (millions)	% of Total
Salary/Wages and Benefits	\$3.5	13.6%
Contracted Professional Services	21.1	81.8%
Operating Supplies and Expenses	1.2	4.5%
Capital Purchases and Equipment	0.0	0.0%
Total	\$25.8	100.0%
SOURCE: RI Department of Administration		

The budgeted \$21.1 million for contracted professional services represents the bulk of this budget request (81.8 percent of total spending). In order of magnitude of spending, the contracted services budgeted for FY 2015 include contracts for: information technology (\$9.0 million); operations and organizational (\$2.6 million); contact center (\$2.4 million); communications and media (\$1.9 million); outreach enrollment support program and in-person assister (\$1.4 million); data and analytics services (\$1.2 million); and staff augmentation (\$1.2 million).¹⁵

¹⁵ This list is not all-inclusive, but, rather, represents those contracted services with contracts over \$1.0 million.