



HealthSource RI: Status Updates

November 2013



RIPEC

Table of Contents

Executive Summary	2
Introduction	4
Rhode Island and the ACA	4
National Updates	5
Limit on Consumer Costs Delayed	5
Employer Mandate Delayed	5
HealthSource RI: Status Updates	6
HSRI Individual/Family Insurance Marketplace	8
Rhode Island’s Premiums, Deductibles, and Cost Sharing	8
Cost-Sharing Reduction	9
Regional Comparison	9
Comparing Averages	9
Deductibles by Category	11
Comparing Similar Blue Cross Blue Shield Plans	12
Blue Cross Blue Shield Silver Plan Comparison	12
Small Business Health Options Marketplace (SHOP)	14
Full Employee Choice	15
Subsidies/Tax Credits	15
Exchange Financing and Insurer Solvency	17
The Cost of Running the Exchange	17
Long-Term Funding Options	18
Accounting for Increased Demand in Care	19
HSRI: Summary of Status	19
Considerations for Implementation	20
Factors for Further Examination	20
Eligibility Requirements	21
Codification into Law	21
Making the Exchange Sustainable	22
Considering Funding Options	23
Articulating and Measuring the Exchange’s Success	24
Breaking Down the Numbers: Medicaid vs. HSRI Enrollment	24
Summary of Considerations	25
Appendix	26
I. Current HSRI Funding Sources	26
II. Comparison of Similar Blue Cross Blue Shield Plans	27

Executive Summary

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law. While there are ten titles in the enacted ACA, the first— “Quality Affordable Health Care for All Americans”— is the most widely cited, as it relates to health insurance reform. Among other provisions, this first title sets out individual and group market reforms, while also calling for the creation of health benefit exchanges in all 50 states. Although the ACA contains a variety of policy mandates that have, and will continue to, impact Rhode Islanders, this RIPEC report focuses on the ACA provision allowing states to establish their own exchanges. This report is intended to update policymakers and the broader public about national and state-level health benefit exchange challenges and progress.

These health benefit exchanges were intended to give individuals and small businesses a specific marketplace in which to buy insurance, with the aim of creating competition and driving down health care costs. Rhode Island opened its online insurance marketplace on October 1, 2013, along with 15¹ other state-operated exchanges, seven partnership exchanges, and 27 federally-run exchanges, with coverage effective January 1, 2014. Rhode Island named its health benefit exchange “HealthSource RI”.

This report focuses on HealthSource RI, examining its rates (premiums and deductibles) in comparison to other New England states, describing the process of purchasing health insurance via both the individual/family and Small Business Health Options (SHOP) marketplace, and offering areas for consideration regarding HSRI’s future. Although the RI exchange is up and running, the exchange must be fiscally self-sustainable by 2015 and codified into law, leaving critical decisions yet to be resolved. This report explores these considerations further, offering a framework for guiding decisions regarding sustainability, codification of law, defining success, and measuring success.

In sum, this RIPEC report found HSRI has:

- Proceeded with minimal technical obstacles, despite federal exchange malfunctions and national delays in the employer mandate and out-of-pocket limits;
- Enrolled 4,405 individuals for insurance through the online HSRI portal in its first month, with 3,213 registering for the state’s Medicaid program and 1,192 individuals registering for private insurance through HSRI;²
- Charged premiums that are among the lowest in New England, but offered deductibles that are among the highest in New England; and
- Been one of seven states offering the full spectrum of full employee choice for small businesses.

For the future of the exchange, HSRI must consider:

- The implications of expanding its definition of small businesses from 0-50 Full Time Employees (FTEs) to the federal definition of 0-100 FTEs in advance of federal law requiring it in 2016;

¹ This number includes Idaho and New Mexico. These states originally planned for state operation, but are currently under partial federal operation due to time constraints.

² HSRI numbers as of November 2, 2013, released November 12, 2013. As of November 9, 2013, 5,166 individuals enrolled in HSRI. This number includes Medicaid enrollment, and has yet to be separated into distinct enrollment type as the first month’s totals were.

- Decisions regarding its organizational structure and where it will be housed within state government, as it must likely shift from an entity created by executive order to an entity codified into state law;
- Establishment of sustainable funding options for 2015 and beyond—Rhode Island is one of six states and the District of Columbia that remains undecided on sustainable funding mechanisms;
- Publicly articulating intended outcomes with measures that clearly define success; and
- The distribution of enrollment numbers (Medicaid enrollees versus HSRI enrollees as a share of total enrollment), and its potential state fiscal implications.

Introduction

On October 1, 2013, online insurance marketplaces opened up nationwide, in accordance with the ACA. Key to this focus were specific provisions beginning January 1, 2014, including:

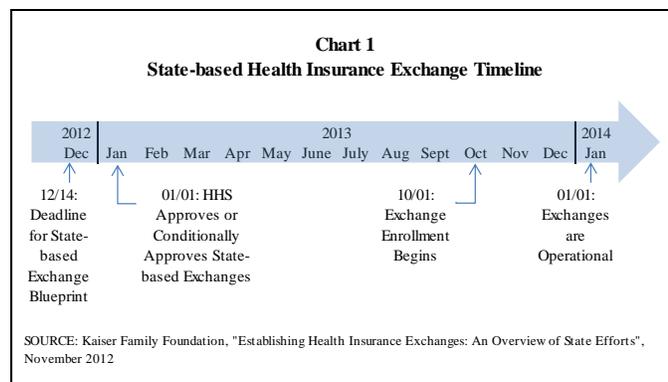
- An individual mandate requiring U.S. citizens and legal residents to maintain health care coverage;
- Expanding the eligibility of Medicaid³ to include those who earn up to 138.0 percent of the Federal Poverty Line (FPL);⁴
- The creation of health benefits exchanges in each state;
- Federal Subsidies to assist qualified individuals and small business owners in obtaining insurance;⁵
- Employer penalties for large companies that do not provide adequate, affordable health care coverage for their workers; and
- A limit on out-of-pocket costs for individual plans (\$6,350) and family plans (\$12,700).

Rhode Island and the ACA

In September 2011, Governor Lincoln Chafee addressed the health benefits exchange provision by establishing the Rhode Island Health Benefits Exchange (RIHBE) as a division within the Executive Department. In December 2012, the federal government gave Rhode Island conditional approval for its state-run exchange, and the 2013 budget moved RIHBE to the Department of Administration.

By October 2013, the RIHBE had received funding from three federal grant sources and one private source totaling about \$83.8 million.⁶ These resources gave Rhode Island the opportunity to construct a portal intended to deliver streamlined and cost-effective service once the exchange was up and running. Enrollment in the exchange began on October 1, 2013 for coverage effective by the January 1, 2014 deadline, as chart 1 shows.

Rhode Island's Health Benefits Exchange, re-named "HealthSource RI" (HSRI) in July 2013, has encountered challenges, but has made progress in the past few months. On the national stage, the employer mandate and limit on out-of-pocket costs was delayed until 2015, generating concerns of potentially unaffordable insurance within the exchange. Statewide, HSRI opened for enrollment in October, announcing its name, rates, plans, new jobs, and a marketing campaign that began in the months leading up to enrollment. While the



³ Medicaid expansion was left at states' option, per the 2012 ACA Supreme Court ruling *National Federation of Independent Business v. Sebelius*.

⁴ Medicaid statute for eligibility is at 133.0 percent of the FPL, with a 5.0 percent disregard (thus, individuals up to 138.0 percent of the FPL are eligible).

⁵ Small business owners, by the ACA definition, are businesses with less than 100 Full-Time Employees (FTEs), working 30 or more hours per week.

⁶ For a breakdown by grant, please see the Appendix.

comprehensive impact of HSRI is unknown, examples from states such as Massachusetts serve as a way to estimate future outcomes. It has been estimated that approximately 124,000 (11.8 percent) of Rhode Islanders are currently uninsured.⁷ HSRI aims to decrease this number over time through private insurance in the competitive marketplace, estimating that 70,000-100,000 (with portions both currently uninsured and insured) may purchase insurance through HSRI in 2014.

National Updates

When the federally-run exchange (www.HealthCare.gov) opened nationally, it faced considerable technological glitches that have dominated public conversation about the exchange. In addition to operationalizing the online federal exchange, the federal government in June of 2013 announced a delay of two important ACA provisions to January of 2015: the limit on out-of-pocket costs and the employer mandate.

Limit on Consumer Costs Delayed

The Obama administration in February 2013 delayed the provision limiting out-of-pocket consumer costs for individual plans (\$6,350) and family plans (\$12,700). The delay, which grants a grace period for insurers, sparked public concern that individuals with chronic disease and a need for expensive medication would be required to continue paying higher prices for longer than expected. However, Rhode Island's rates do not reflect this cap delay, as out-of-pocket rates for 2014 are held at the previously required cap for individual plans (\$6,350) and family plans (\$12,700) by Blue Cross Blue Shield of Rhode Island for certain Silver, Bronze, and Catastrophic-level plans.

Employer Mandate Delayed

In June 2013, President Obama's administration announced the delay of the employer mandate provision to 2015. The original provision required employers with more than 50 employees to provide an insurance option or face a penalty. Companies with fewer than 100 employees, or 50 employees according to Rhode Island state law, would (and still will) be able to purchase health insurance through the Small Business Health Options Program (SHOP), part of the health benefits exchanges nationwide.

The one-year delay means that employers (large businesses, which means businesses with 50 or more employees in Rhode Island) are not required to provide insurance until 2015, generating concerns that, without an incentive for businesses, many individuals will forgo insurance in 2014. However, recent research suggests that the delay of the employer mandate would have different results. For instance, it found that the delay would have far less impact on individuals, who are still held accountable for insurance through the individual mandate, than it would on federal government revenue.⁸ This research suggests the government would lose the \$3.7 billion that is expected to be collected from employer penalties, a finding similar to that of the

⁷ "Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States." Robert Wood Johnson Foundation and the Urban Institute, October 2013.

⁸ "It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs than the Individual Mandate." The Urban Institute, July 15, 2013.

Congressional Budget Office.⁹ Additionally, with fewer small businesses expected to enroll in the Small Business Health Options (SHOP) marketplace, federal spending on subsidies is expected to decrease by \$300 million.

However, the employer delay has also generated some concerns regarding the possibility of adverse selection. For example, healthy, young individuals may forgo insurance while large numbers of older individuals with pre-existing conditions purchase insurance, resulting in a narrow, high-risk pool with higher costs. While the federal risk adjustment and reinsurance programs (see page 19) were created to ease transition to the exchange and minimize adverse selection, outcomes relating to adverse selection remain unknown and of concern to HSRI officials, state leadership, and the public as a whole.

HealthSource RI: Status Updates

**Table 1
2013 Federal Poverty Guidelines**

Household Size	Percent of Federal Poverty Line						
	100%	138%	150%	185%	200%	300%	400%
One	\$11,490	\$15,856	\$17,235	\$21,257	\$22,980	\$34,470	\$45,960
Two	15,510	21,404	23,265	28,694	31,020	46,530	62,040
Three	19,530	26,951	29,295	36,131	39,060	58,590	78,120
Four	23,550	32,499	35,325	43,568	47,100	70,650	94,200
Five	27,570	38,047	41,355	51,005	55,140	82,710	110,280
Six	31,590	43,594	47,385	58,442	63,180	94,770	126,360

For each additional person, add \$4,020/year for families at 100% of poverty

The state health benefit exchanges are online insurance marketplaces for individuals and small businesses to purchase both public (Medicaid) and private (HSRI and SHOP) insurance. Individuals earning between 0.0 to 138.0 percent of the Federal Poverty Line (FPL) may enroll in Medicaid, as the online portal will deem them eligible for this public, fully-funded, single-plan option. The individual/family exchange portion of the marketplace, HSRI, was created with the intent of offering a selection of affordable, private insurance to individuals earning between 100.0 and 400.0 percent of the FPL without access to affordable, employer-based

insurance. However, any individual or family may purchase insurance from the exchange, regardless of eligibility for subsidies. Table 1 shows the minimum and maximum annual eligible incomes required for enrollment in HSRI, from individuals (\$11,490 to \$45,960) to six-person family units (\$31,590 to \$126,360).

The penalty for foregoing insurance is \$95 or 1.0 percent of an individual’s income, whichever is higher, and will increase each year the exchange operates. The ACA also makes it possible for individuals to receive subsidies, both on a sliding scale based on their income through the individual/family marketplace and through a cost sharing reduction that limits out-of-pocket costs and co-payments. It is expected that 40,000 Rhode Islanders will qualify for subsidies.¹⁰ For small businesses, the Small Business Health Options Program (SHOP) provides a combination of insurance plans for employees toward which a small business employer can contribute. If small businesses contribute at least 50.0 percent toward the cost of their employees’ insurance, they are eligible for tax credits worth 50.0 percent of their total cost, on an annual basis.

In July 2013, HSRI announced the insurance providers joining its online marketplace. Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), and UnitedHealthcare (UHC) are participants in the health care exchange. As table 2 shows, UHC joined the marketplace in the small business insurance capacity (SHOP) only, while NHPRI and BCBSRI joined the marketplace to cover both individuals and businesses via SHOP.

Table 2 Carriers on HSRI	
Individual/Family Marketplace	Small Businesses (SHOP)
Neighborhood Health Plan of Rhode Island	Neighborhood Health Plan of Rhode Island
Blue Cross Blue Shield of Rhode Island	Blue Cross Blue Shield of Rhode Island
	UnitedHealthcare

⁹ “Announcement of the Administration’s Announced Delay of Certain Requirements Under the Affordable Care Act.” Congressional Budget Office, July 13, 2013.

¹⁰ “State-by-State Estimates of the number of people eligible for premium tax credits under the ACA.” Kaiser Family Foundation, Nov. 5, 2013

Table 3
HealthSource RI - Premium and Deductible Rates per Plan - Individual/Family Marketplace

Federal Plan Categories Insurance Company	Gold				Silver				Bronze			Catastrophic Plan*
	BCBSRI	BCBSRI	BCBSRI	NHPRI*	BCBSRI	BCBSRI	BCBSRI	NHPRI*	BCBSRI	BCBSRI	BCBSRI	BCBSRI
Plan Name	BlueSolutions for HSA Direct 1500/3000	VantageBlue Direct 500/1000	VantageBlue Select/RI Direct 500/1000	Neighborhood Health Plan of RI Plus	BlueSolutions for HSA Direct 2600/5200	VantageBlue Direct 3000/6000	VantageBlue Select RI Direct 3000/6000	Neighborhood Health Plan of RI Value	BlueSolutions for HSA Direct 5000/1000	VantageBlue Direct 5800/11600	VantageBlue SelectRI Direct 5800/11600	BasicBlue Direct
Monthly Premium (Rate for 21-year-old)	\$261	\$276	\$282	\$269	\$214	\$230	\$235	\$232	\$166	\$169	\$177	\$150
Monthly Premium (Rate for 40-year-old)	\$334	\$353	\$361	\$344	\$274	\$294	\$300	\$296	\$212	\$216	\$226	\$192
Monthly Premium (Rate for a 60-year-old)	\$709	\$750	\$766	\$731	\$582	\$625	\$637	\$629	\$451	\$458	\$479	\$407
Network Type	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO) with Tiers	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO) with Tiers	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO) with Tiers	Preferred Provider Organization (PPO)
Other Features	HSA (Health Savings Account) Qualified	N/A	N/A	N/A	HSA (Health Savings Account) Qualified	N/A	N/A	N/A	HSA (Health Savings Account) Qualified	N/A	N/A	Catastrophic Plan
Deductible - Medical	\$1,500 Individual \$3,000 Family	\$1,500 Individual \$2,000 Family	\$500 Individual \$1,000 Family	\$2,000 Individual \$4,000 Family	\$2,600 Individual \$5,200 Family	\$3,000 Individual \$6,000 Family	\$3,000 Individual \$6,000 Family	\$3,000 Individual \$6,000 Family	\$5,000 Individual \$10,000 Family	\$5,800 Individual \$11,600 Family	\$5,800 Individual \$11,600 Family	\$6,350 Individual \$12,700 Family
Deductible - Drug	Combined with Medical	N/A	N/A	\$100 individual \$200 Family	Combined with medical	N/A	N/A	N/A	Medical	\$500 Drug	\$500 Drug	Combined with Medical
Max. out-of-Pocket Medical	\$2,250 Individual \$4,500 Family	\$4,000 Individual 8,000 Family	\$4,000 Individual \$8,000 Family	\$4,000 Individual \$8,000 Family	\$4,000 Individual \$8,000 Family	\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family	\$5,000 Individual \$10,000 Family	\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family	\$6,350 Individual \$12,700 Family
Max. out-of-Pocket Drug	N/A	N/A	N/A	\$500 Individual \$1,000 Family	N/A	N/A	N/A	\$500 Individual \$1,000 Family	N/A	N/A	N/A	N/A

* These plans are only available to those under 30 years of age, or an individual with a plan deemed unaffordable

SOURCE: HealthSource RI

Table 5
2013 Federal Poverty Guidelines and Maximum Premiums*

Household Size	Percent of Federal Poverty Line and Maximum Premium (with Federal Subsidy)																				
	100%	Max. Annual Premium*	Max. Monthly Premium	138%	Max. Annual Premium*	Max. Monthly Premium	150%	Max. Annual Premium*	Max. Monthly Premium	185%	Max. Annual Premium*	Max. Monthly Premium	200%	Max. Annual Premium*	Max. Monthly Premium	300%	Max. Annual Premium*	Max. Monthly Premium	400%	Max. Annual Premium*	Max. Monthly Premium
One	\$11,490	\$230	\$19	\$15,856	\$523	\$44	\$17,235	\$862	\$72	\$21,257	\$1,105	\$92	\$22,980	\$1,609	\$134	\$34,470	\$3,275	\$273	\$45,960	\$4,366	\$364
Two	15,510	310	26	21,404	706	59	23,265	1163	97	28,694	1435	120	31,020	2171	181	46,530	4420	368	62,040	5894	491
Three	19,530	391	33	26,951	889	74	29,295	1465	122	36,131	1807	151	39,060	2734	228	58,590	5566	464	78,120	7421	618
Four	23,550	471	39	32,499	1072	89	35,325	1766	147	43,568	2178	182	47,100	3297	275	70,650	6712	559	94,200	8949	746
Five	27,570	551	46	38,047	1256	105	41,355	2068	172	51,005	2550	213	55,140	3860	322	82,710	7857	655	110,280	10477	873
Six	31,590	632	53	43,594	1439	120	47,385	2369	197	58,442	2922	244	63,180	4423	369	94,770	9003	750	126,360	12004	1000

For each additional person, add \$4,020/year for families at 100% of poverty

*This is the maximum annual premium (2.0-9.5 percent of one's income) an individual would pay toward insurance. The government would subsidize the difference between plan's cost and an individual's payment. Figures represent sliding scale income proportion estimates.

SOURCE: Kaiser Family Health Foundation Subsidy Calculator, Community Catalyst, Georgetown University Policy Institute and RIPEC Calculations

Tufts Health Plan (THI) is scheduled to join the marketplace in January 2015.

In August 2013, HSRI announced its rates for individual, family, and SHOP plans. The individual/family marketplace has 12 insurance plans available, while the SHOP marketplace has 16 plans. This section explains the rates for each marketplace.

HSRI Individual/Family Insurance Marketplace

As per the ACA, HSRI's rates are based exclusively on age and desired plan. Gender and pre-existing conditions do not factor into premium and deductible prices within HSRI. This information is reflected in table 3, which shows the rates, deductibles, network type, and maximum out-of-pocket costs for those purchasing insurance through the individual/family marketplace.¹¹ These benefits offered through HSRI can be compared to those outside the exchange in Rhode Island, as well as to plans in other states.

Rhode Island's Premiums, Deductibles, and Cost Sharing

As table 3 also shows, Rhode Island's premium rates for 21-year-olds to 60-year-olds range from \$150 to \$407 per month on Catastrophic plans, to \$261 to \$709 per month on Gold plans.¹² Deductibles range from a low of \$500 (for individuals) and \$1,000 (for families) on the Gold BCBSRI Vantage Blue Select/RI Direct 500/1000 and a high of \$5,800 (for individuals) and \$11,600 (for families) on two BCBSRI Bronze plans: Vantage Blue Direct 5800/11600, Vantage Blue Select/RI Direct 5800/11600. The Catastrophic category's Basic Blue Direct charges the highest deductibles, at \$6,350 for individuals and \$12,700 for families.

Age	HSRI	BCBSRI (web site) - Male Applicant
21 year-old	\$230	\$230
40-year-old	294	293
60-year-old	625	623

SOURCE: HSRI rate sheets, BCBSRI Web site

The ACA and its exchange subsidies were intended to make the second-lowest-cost Silver plan (Vantage Blue Direct 3000/6000 in HSRI) affordable for all individuals. Of note, HSRI's BCBSRI Vantage Blue Direct Plan's pricing for 21-year-olds to 60-year olds in the Silver category is almost identical to a direct purchasing of the same plan on the BCBSRI's web site. As table 4 indicates, premiums within the exchange are comparable to the premiums of the same plans outside of the exchange. However, on HSRI, consumers with

salaries ranging from 100.0 to 400.0 percent of the FPL will be eligible for subsidies, effectively reducing the cost of the same plan.

Table 5 (on the prior page), shows the maximum monthly premiums and annual total in monthly premiums an individual will be required to pay, on a sliding scale, according to their income. Again, this subsidy is intended to make the second-lowest-cost Silver plan (Vantage Blue Direct 3000/6000 in HSRI) affordable to all HSRI participants. Consumers may choose to pay more for Gold plans and less for Bronze or Catastrophic plans.

Table 6 illustrates this sliding scale, outlining how premium limits, as a percent of income, increase as income within the exchange threshold rises.

Income (as % FPL)	Premium Limit (% of income)
< 133%	2.0%
133-150%	3.0-4.0%
150-200%	4.0-6.3%
200-250%	6.3-8.05%
250-300%	8.05-9.5%
300-400%	9.50%

SOURCE: Community Catalyst and Georgetown University Policy Institute

¹¹ All plans services and preventative services encompassing, but not limited to: Ambulatory patient services and outpatient care; Hospitalization; Maternity and newborn care; Mental health substance abuse treatment services; Prescription drugs; Blood pressure and cholesterol screening; Breast cancer screening and mammography; Cervical cancer screening (pap smear).

¹² Catastrophic plans are exclusively for those under the age of 30, or for those with a plan deemed unaffordable.

For example, if an individual making 185.0 percent of the Federal Poverty Line (FPL) (\$21,257 annually) purchases a plan that requires them to pay more than \$1,105 annually in premium costs (\$92 a month, or about 5.2 percent of their annual income), the government will subsidize the remaining cost. If this individual making 185.0 percent of the FPL is 40-years-old and purchases the BCBSRI Vantage Blue Direct Silver plan, which costs them \$3,528 annually (\$294 a month), 68.6 percent will be covered by the federal premium subsidy. In context, the lowest monthly premium among Rhode Island’s health plans is in the Catastrophic category, at \$150 per month, amounting to \$1,800. This is more than 3.3 percent of the annual income of an individual making 138.0 percent of the FPL. Thus, any individual with an annual income at 138.0 percent of the FPL (21 years or older) who purchases insurance at the exchange (in any category) will be subsidized, so that their total payment does not exceed \$523 per year, regardless of the plan they purchase.

Maximum out-of-pocket payments are the greatest amount of money one spends on insurance in a year, in addition to the monthly premium. This includes deductibles, co-payments, and co-insurance. Table 3 shows maximum out-of-pocket costs remaining at the 2015 cap for individuals and families on all plans within HSRI, despite the delay on out-of-pocket cost limits. The dark shaded boxes for plans in the Silver, Bronze, and Catastrophic categories illustrate the plans in which out-of-pocket maximums are held at the cap.

Cost-Sharing Reduction

In addition to income-based premium subsidies on HSRI, individuals may receive cost-sharing assistance, called a cost-sharing reduction. The cost-sharing reduction reduces the out-of-pocket payments listed above, including deductibles, co-payments, and co-insurance. In order to receive a cost sharing reduction, an individual or family’s income must be below 250.0 percent of the FPL (\$28,725 for individuals), and they must purchase a plan in the Silver category. Table 7 shows the cost-sharing reduction income threshold for individuals and families of different sizes as of 2013. The income threshold will likely be higher in 2014.

Family Size	Income Threshold (Must Be Below)
1	\$28,725
2	38,755
3	48,825
4	58,875
5	68,925
6	78,975
7	89,025
8	99,075

SOURCE: HealthCare.gov

Regional Comparison

Regionally, Rhode Island’s average premium rates in the individual/family marketplace are among the lowest in New England across age and category, as table 8 shows.¹³ This section compares plan averages in each age category across New England as well as similar Blue Cross Blue Shield plans in each category across New England.¹⁴ Of note, Vermont and Massachusetts are the only states offering plans in the Platinum category, and Rhode Island, Massachusetts, and Maine are the only states offering plans in the Catastrophic category within the individual/family HSRI marketplace. For this reason, this report solely compares rates in the Gold, Silver, and Bronze categories.

Comparing Averages

Exchange marketplace averages by age and category across New England indicate that Rhode Island’s premiums are among the lowest in New England, while its deductibles are among the

¹³ When geography was used as a rate factor, all geographic regions were averaged (excluding Massachusetts). To compare Massachusetts, rates and deductibles for the New Bedford region were used, as the region is geographically close to Rhode Island.

¹⁴ All plans compared in this section are within the individual/family marketplace only.

Table 8
Regional Health Benefits Exchange Rates: State Averages per Age and Plan Type *

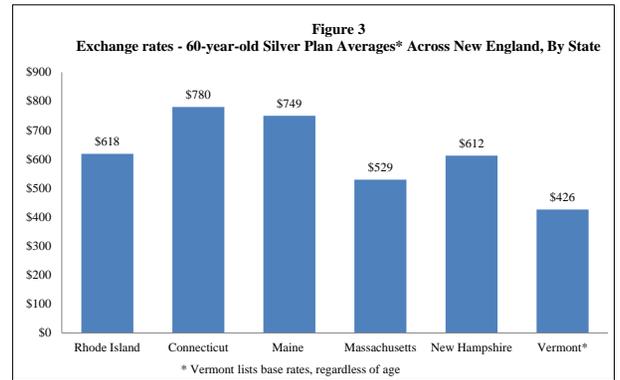
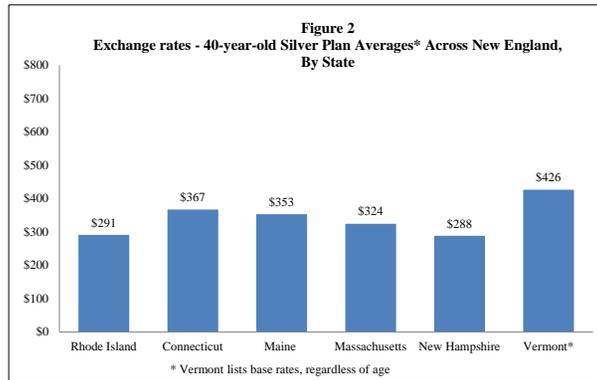
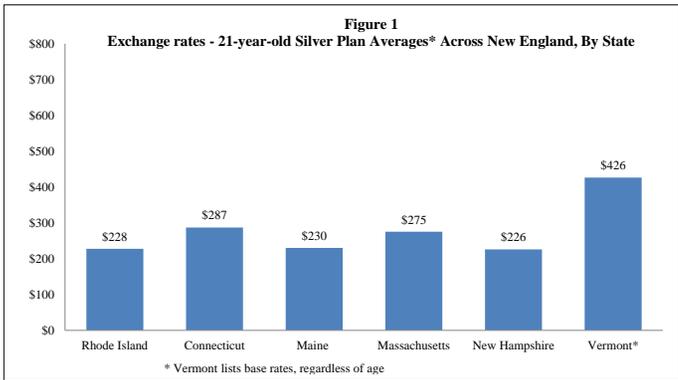
State	# of Plans In Exchange	Age (Years old)	Plan Type								
			Gold			Silver			Bronze		
			Premiums	Deductibles		Premiums	Deductibles		Premiums	Deductibles	
		Individual	Family		Individual	Family		Individual	Family		
<i>Rhode Island</i>	12	21	\$272			\$228			\$171		
		40	348	\$1,250	\$2,500	291	\$2,900	\$5,800	218	\$5,738	\$11,475
		60	739			618			463		
Connecticut	3	21	228			287			318		
		40	291	1,000	2,000	367	3,000	6,000	407	3,250	6,500
		60	618			780			864		
Maine**	2	21	294			230			187		
		40	443	883	N/A	353	2,617	N/A	287	5,583	N/A
		60	941			749			609		
Massachusetts	95	21	350			275			231		
		40	413	1,653	2,148	324	1,989	3,939	264	2,000	4,000
		60	668			529			429		
New Hampshire**	1	21	177			226			177		
		40	227	1,000	N/A	288	2,500	N/A	227	5,750	N/A
		60	482			612			482		
Vermont***	2	Base Rate - Individual	505	833	N/A	426	2,867	N/A	348	3,333	N/A

* Regional comparison includes all geographic areas of states, excluding Massachusetts (New Bedford zip code was used) and Connecticut (New London zip code was used). Total plans in exchange (95 and 3) exist in every county statewide.

** Federally Operated.

*** Excludes high deductible plans (which are paired with a health savings account). Base rates are listed instead of averages.

SOURCE: State Health Benefits Exchange Web sites, RIPEC calculations



highest. As figures 1 through 3 illustrate, Rhode Island’s premiums are most similar in price to exchanges in New Hampshire and Maine (both are federally-operated).

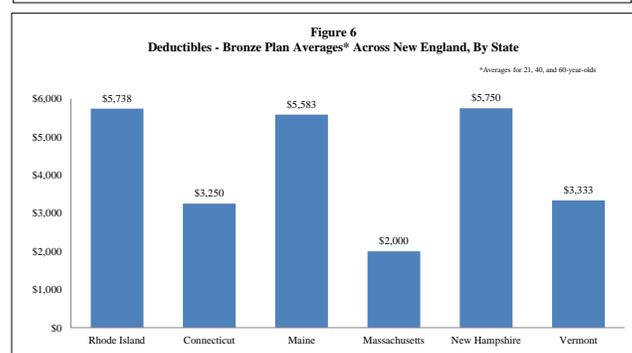
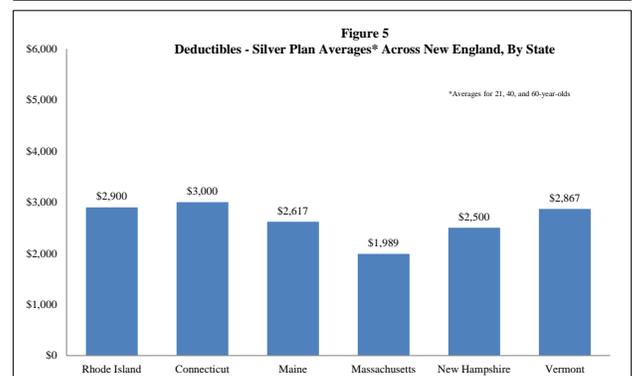
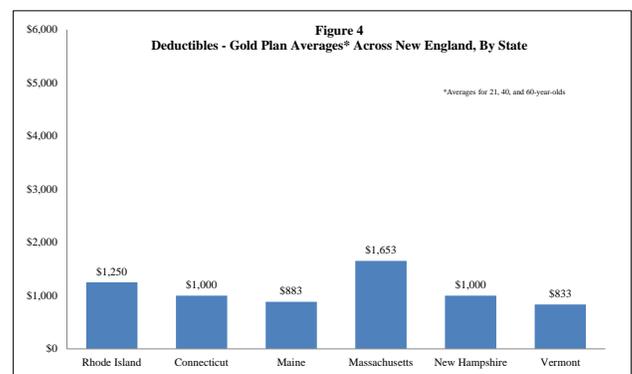
HSRI in Rhode Island was expected to increase the rates of younger age groups and decrease the rates of older age groups because of compressed rating bans. Although rates are slightly higher for younger exchange consumers, they remain significantly lower than those of individuals aged 60 years or older. Figures 1 through 3 show monthly premium rate averages in the Silver Plan for 21-year-olds (figure 1), 40-year-olds (figure 2), and 60-year-olds (figure 3) across New England, by state. Rhode Island’s rates are the second-lowest for 21- and 40-year olds, as figures 1 and 2 show, at \$228 and \$291 per month, just above New Hampshire (\$226 and \$288). Yet, Rhode Island’s rates are second-highest in New England in the 60-year-old age bracket, at \$618, just below Maine (\$749) and just above New Hampshire (\$612). Rhode Island’s individuals in the 60-year-old age bracket on HSRI must pay an average of \$390 and \$327 more per month than Rhode Island’s 21- and 40-year-olds, respectively.

Further, rate shock, or dramatically different rates as a result of exchange establishment, was not as much of a factor in Rhode Island because of numerous health insurance mandates and work between the Office of the Health Insurance Commissioner and health insurance companies, which have kept Rhode Island’s rates traditionally higher than those of other New England states while keeping its health care options more comprehensive. Consequently, Rhode Island’s individual exchange rates are, as mentioned previously, comparable to Rhode Island’s private health insurance premiums outside of HSRI.

Deductibles by Category

This section details average individual deductibles (for 21-, 40-, and 60-year-olds) in each comparison category within HSRI’s individual/family market (Gold, Silver, and Bronze), across New England. Rhode Island’s average deductibles are among the highest in New England in the Gold, Silver, and Bronze categories.¹⁵

Figure 4 shows that Rhode Island’s average Gold plan deductible is the second-highest in New England, at \$1,250—below Massachusetts (\$1,653), and above Connecticut and New Hampshire (\$1,000 each). Vermont and Maine have the lowest average individual deductible in the Gold category (\$833).



¹⁵ The deductible comparison makes use of Vermont and Connecticut’s base deductibles.

Figure 5 illustrates that Rhode Island's average individual deductible in the Silver category is the second-highest in the region, at \$2,900, just below Connecticut (\$3,000) and above Vermont (\$2,867).¹⁶ Deductibles are in addition to the Silver plan premiums illustrated in figures 1-3. Massachusetts's base deductible in the Silver category is the lowest, at \$1,989.

Figure 6 shows that Rhode Island's average deductible in the Bronze categories is the second-highest in the New England region, at \$5,738, below New Hampshire (\$5,750), and above Maine (\$5,583). Massachusetts has the lowest average deductible in the Bronze category, at \$2,000.

Comparing Similar Plans—Blue Cross Blue Shield

For a more precise comparison across states, it is helpful to identify a similar plan with a similar price structure and benefits, as these plans provide a more accurate glimpse of rate trends in each state. Because Blue Cross Blue Shield (BCBS) was the only carrier offering health insurance in all six New England states, this section compares similar BCBS standard plans across states. Rhode Island's Vantage Blue Direct (the second-lowest-cost plan in the Silver category, which is to be used as the baseline for affordability in the ACA) was used as a baseline, matched with other standard BCBS plans in states where BCBS offers multiple plans. In states where only one BCBS plan is offered, that standard BCBS plan was used.

Comparing similar BCBS plans across New England illustrates that HSRI generally charges lower premiums and higher deductibles than neighboring states. As table 9 shows, Rhode Island's baseline BCBS Vantage Blue Direct included monthly premium rates ranging from lows of \$169 (21-year-olds), \$216 (40-year-olds), and \$458 (60-year-olds) in the Bronze category, to highs of \$276 (21-year-olds), \$353 (40-year-olds), and \$750 (60-year-olds) in the Gold category. Deductibles, which are the same across age, range from a high of \$5,800 for individuals in the Bronze category to a low of \$1,000 for individuals in the Gold category.

Table 9 also provides a comparison of HSRI's BCBS Vantage Blue Direct Plan, with similar plans in New England. The comparison across age brackets suggests that Rhode Island's premiums are generally lower than its New England neighbors. Furthermore, figures 7-9 show premium rates for similar BCBS plans across New England in the Silver category for 21-year-olds, 40-year-olds, and 60-year-olds. Additional figures comparing similar BCBS plan premiums and deductibles across New England in the Bronze and Gold categories are available in the Appendix.

Blue Cross Blue Shield Silver Plan Comparison

In terms of the BCBS Silver Plan classification, as figure 7 shows, Rhode Island's Vantage Blue Direct 3000/6000 offers the second-lowest monthly BCBS plan premium rates for 21-year-olds in New England, at \$230, just above a similar BCBS plan in New Hampshire (\$226), and just below a similar BCBS plan in Maine (\$239). Vermont's BCBS plan charges the highest monthly base premium for 21-year-olds in the Silver category, at \$426. Excluding base rates, Massachusetts' BCBS plan has the highest premium in the Silver category, at \$350.

Figure 8 shows premium rates for similar BCBS plans across New England for 40-year-olds in the Silver category. Again, Rhode Island's BCBS Vantage Blue Direct 3000/6000 offers the second-

¹⁶ Rhode Island and Connecticut are the only two states in the New England Region with both individual and family deductibles included on their rate sheets. For comparison purposes, only individual deductibles are compared.

Table 9
Blue Cross Blue Shield Rates (Selected Plans Listed) Across New England*

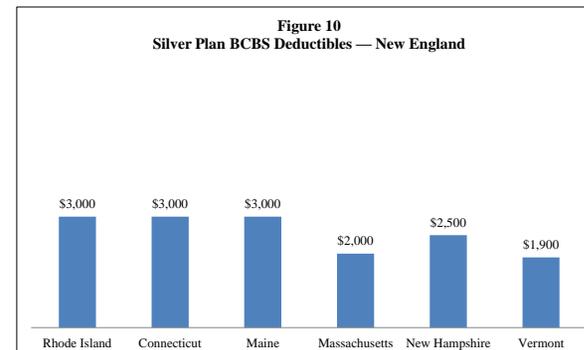
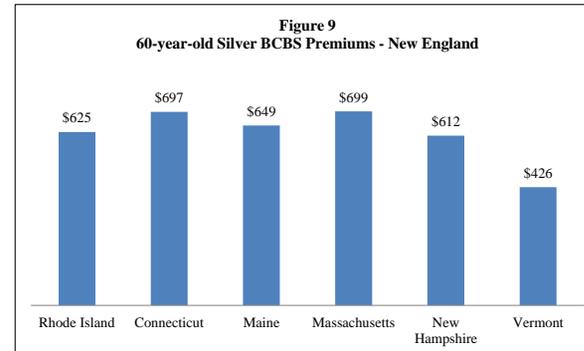
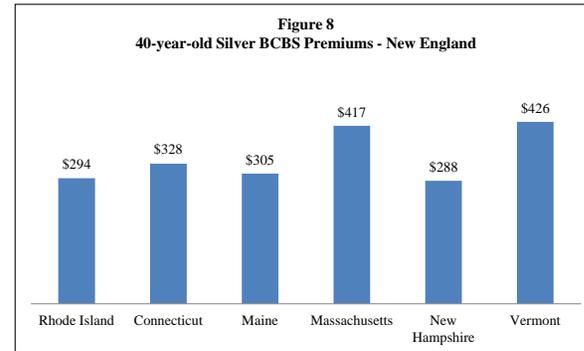
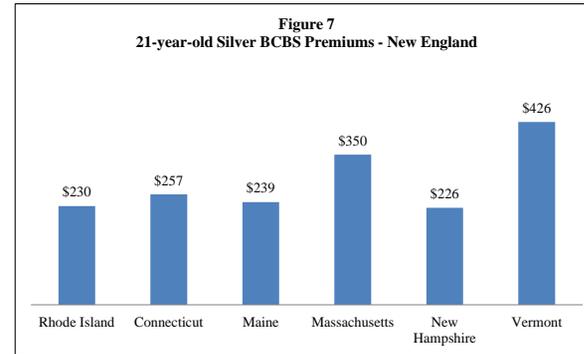
State	BCBS Plan	Age (Years old)	Plan Type					
			Gold		Silver		Bronze	
			Premiums	Deductibles Individual	Premiums	Deductibles Individual	Premiums	Deductibles Individual
Rhode Island	Vantage Blue Direct	21	\$276		\$230		\$169	
		40	\$353	\$1,000	\$294	\$3,000	\$216	\$5,800
		60	\$750		\$625		\$458	
Connecticut	Anthem Bronze, Silver, and Gold Direct Access — Standard	21	298		257		203	
		40	381	1,000	328	3,000	260	3,250
		60	809		697		551	
Maine**	BCBS Anthem Non-Tobacco	21	295		239		184	
		40	377	750	305	3,000	235	5,750
		60	800		649		498	
Massachusetts	BCBS, Multi-State Plan and BCBS Basic, Multi-State Plan	21	408		350		320	
		40	486	1,500	417	2,000	381	2,000
		60	816		699		639	
New Hampshire**	BCBS Anthem Blue	21	268		226		177	
		40	342	1,000	288	2,500	277	5,750
		60	727		612		482	
Vermont****	Standard BCBS **Base Rate		505	750	426	1,900	348	3,500

* Regional comparison includes all geographic areas of states, excluding Massachusetts (New Bedford zip code was used), Connecticut (New London zip code was used), and Maine (Cumberland County rates were used).

** Federally Operated.

**** Excludes high deductible plans (which are paired with a health savings account). New London County's rates were used. Base rates are listed instead of averages

SOURCE: State Health Benefits Exchange Web sites, RIPEC calculations



lowest monthly premiums in New England, at \$294 — just above a similar BCBS plan in New Hampshire (\$288) and just below a similar BCBS plan in Maine (\$305). Vermont’s BCBS plan charges the highest monthly base premiums for 40-year-olds in the Silver category, at \$426, and Massachusetts’ BCBS plan charges the highest monthly premium (excluding base rates), at \$417.

Moreover, figure 9 shows premium rates for similar BCBS plans across New England for 60-year-olds in the Silver category. Rhode Island’s Vantage Blue Direct 3000/6000 offers the second-lowest monthly premium rates in New England, at \$625 — just above a similar BCBS plan in New Hampshire (\$612) and just below a similar BCBS plan in Maine (\$649). Vermont’s BCBS plan charges the lowest monthly base premium for 40-year-olds in the Silver category, at \$426, while Massachusetts and Connecticut’s BCBS plans charge the highest (\$699 and \$697).

As illustrated by figure 10, deductibles do not vary with age. Again, Rhode Island’s deductibles in the Silver category for similar BCBS plans are the highest in New England, at \$3,000, along with Connecticut and Maine (\$3,000 each). Vermont’s BCBS plan charges the lowest deductibles, at \$1,900.

Small Business Health Options Marketplace (SHOP)

The Affordable Care Act (ACA) originally charged employers with 50 or more full-time equivalent (FTE) employees to provide affordable, minimum-value health insurance coverage for full-time employees. As the previous section stated, this element of the ACA has been postponed one year, to 2015. However, Rhode Island’s exchange is functioning as if the employer mandate was still in effect, in anticipation of its commencement in 2015.

Employers with fewer than 50 FTEs (employees working 30 or more hours per week, according to the ACA) are exempt from any employer responsibility in the ACA. However, in Rhode Island these employers have access to the state’s Small Business Health Options Program (SHOP), a marketplace within the state’s exchange. By leveraging the purchasing power of the state’s exchange population, distributing administrative costs, and potentially diluting the small group risk pool, companies may realize savings by purchasing health insurance coverage through SHOP. Further, SHOP gives employers the option to define a benefit by selecting a plan for their employees, or define a contribution toward a specific plan. Defining a contribution also grants employees the choice to supplement the employer contribution if a more expensive plan is desired.

Rhode Island’s FTE formula differs from those of the federally operated exchanges. To determine the total number of FTEs in a firm according to HSRI, small business employers can count the number of employees they currently insure, regardless of their status as full- or part-time employees. If a firm currently insures 50 employees or less, these employees and their dependent children are eligible for the appropriate health insurance benefits within SHOP.

Table 10 shows Rhode Island’s small businesses, according to the federal definition (fewer than 100 employees), comprise 98.2 percent of the state’s total firms, and 52.0 percent of the state’s workforce. However, only those businesses with 50 or fewer employees (40.4 percent of the total work force) will have access to the plans provided through the state’s SHOP. The nature of the program, and the, as yet, undetermined method of financing associated with exchange operations, could impact plan affordability and participation.

Full Employee Choice

# of Employees	# of Firms	% of Total	# Employed	% of Total
Less than 50	30,494	96.2%	154,719	40.4%
50-99	642	2.0%	44,465	11.6%
100+	558	1.8%	183,993	48.0%
Total	31,694	100.0%	383,177	100.0%

SOURCE: RI DLT, data as of March 2012

Small employers will have support from brokers in directing their employees through SHOP.

Rhode Island is one of seven states offering full employee choice among all plans and levels of coverage, or categories. This means that, as employers, small businesses have the option to define a benefit or a contribution, by:

- Choosing a carrier and a plan for employees; or
- Choosing a dollar amount that reflects a baseline carrier/plan.

These options are intended to give employees the ability to choose a plan that best suits their needs. For example, if an employer opts to send an employee to SHOP with a fixed dollar amount, the employee can choose any plan and pay the difference (see table 11). This means that, if an employer selected Carrier B Plan 1 as the baseline plan as shown in table 11, and funded the contribution in full, the employee would have no additional required contribution to enroll in this plan. If the employee instead opted for Carrier A Plan 3, Carrier A Plan 2, or Carrier B Plan 2, the employee would contribute an additional \$15,000 or \$1,000 to enroll in the plan. Conversely, if the employee selected Carrier A Plan 1, a plan less costly than the defined contribution, the employer’s bill would be reduced by the difference between the contribution and lower cost plan (with no refund to the employee).

Rates

Table 12 shows the rates for SHOP, with all plans providing the same minimum coverage as the individual/family exchange marketplace. Small business employers are instructed to request the age of each employee and their dependent, which determines the premium cost per family. After gathering information from each family, the employer may average the premium costs and select a plan or cost contribution best suited to their employees’ needs.

Table 12 also illustrates Rhode Island’s individual premium rates for 21-year-olds to 60-year-olds, ranging from \$378 and \$1,025 per month on Platinum plans to \$187 and \$508 per month on Bronze plans.

Deductibles range from a low of \$250 (for individuals) and \$500 (for families) on the Platinum BCBSRI Vantage Blue 100/80 and a high of \$5,000 (for individuals) and \$10,000 (for families) on the BCBSRI Bronze plans Blue Solutions for HSA 100/60.

Subsidies/Tax Credits

A small business must contribute at least 50.0 percent of the premium cost for their employees to receive any small business tax credit, equal up to 50.0 percent of the contributed premium cost. Small business tax credits are calculated according to a federal sliding scale based on size of business and wages of employees. To be eligible, small businesses must employ 25 FTEs or less, and these employees must earn an annual average salary of less than \$50,000. This payment will be up-front, and the employer will receive a government tax break when completing their taxes. The remaining premium cost may be deducted from the rest of the small business employer’s taxes.

Table 11 Hypothetical Employee Plan Selection
<p>Carrier A Plan 3</p> <p>Cost of Plan = SX+\$1500</p> <p>Employer Contribution = SX</p> <p>Employee Contribution = \$1500</p>
<p>Carrier B Plan 2</p> <p>Cost of Plan = SX+\$1000</p> <p>Employer Contribution = SX</p> <p>Employee Contribution = \$1000</p>
<p>Carrier A Plan 2</p> <p>Cost of Plan = SX+\$1000</p> <p>Employer Contribution = SX</p> <p>Employee Contribution = \$1000</p>
<p>Employer Baseline Plan Carrier B Plan 1</p> <p>Cost of Plan = SX</p> <p>Employer Contribution = SX</p> <p>Employee Contribution = \$0</p>
<p>Carrier A Plan 1</p> <p>Cost of Plan =SX-\$500</p> <p>Employer Contribution = SX-500 (Employer bill is reduced)</p> <p>Employee Contribution = \$0</p>

**Table 12
HealthSource RI - Premium and Deductible Rates per Plan - SHOP**

Federal Plan Categories	Platinum			Gold						Silver					Bronze	
	Insurance Company	BCBSRI	BCBSRI	BCBSRI	BCBSRI	BCBSRI	BCBSRI	NHPRI	UHC	UHC	BCBSRI	BCBSRI	UHC	UHC	NHPRI	BCBSRI
Plan Name	Vantage Blue 100/80	Vantage Blue 100/80	BCHO Advantage 100/No OON	Blue Solutions for HSA 100/60	Vantage Blue 100/60	VantageBlue Select RI 100/80/50	Neighborhood Plan of RI Premier	UnitedHealthcare Edge Gold Plan (UP-V)	UnitedHealthcare Balanced Gold Plan (RH-8)	BlueSolutions for HSA 85/60	VantageBlue 70/50	UnitedHealthcare Edge HSA Silver Plan (R9-6)	UnitedHealthcare Balanced Silver Plan	Neighborhood Health Plan of RI Choice	Blue Solutions for HSA 100/60	UnitedHealthcare Edge USA Bronze Plan (R9-4)
Monthly Premium (Rate for 21-year-old)	\$378	\$357	\$350	\$289	\$305	\$295	\$278	\$305	\$300	\$245	\$250	\$211	\$257	\$238	\$187	\$203
Monthly Premium (Rate for 40-year-old)	\$483	\$456	\$447	\$369	\$390	\$377	\$355	\$389	\$384	\$313	\$320	\$269	\$328	\$304	\$239	\$260
Monthly Premium (Rate for 60-year-old)	\$1,025	\$968	\$949	\$784	\$829	\$802	\$754	\$827	\$815	\$665	\$680	\$572	\$697	\$646	\$508	\$552
Network Type	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Point of Service (POS)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO) with Tiers	Health Maintenance Organization (HMO)	Tiered	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)	Preferred Provider Organization (PPO)	Tiered	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)	Tiered
Deductible - Medical	\$250 Individual, \$500 Family	\$500 Individual, \$1,000 Family	\$750 Individual, 1,500 Family	\$1,500 Individual, \$3,000 Family Combined with Medical	\$1,500 Individual, \$3,000 Family	\$2,000 Individual, \$4,000 Family	\$2,000 Individual, \$4,000 Family	\$1,000 Individual, \$2,000 Family	\$1,500 Individual, \$3,000 Family	\$2,000 Individual, \$4,000 Family	\$2,000 Individual, \$4,000 Family	\$2,000 Individual, \$4,000 Family	\$2,000 Individual, \$4,000 Family	\$2,000 Individual, \$4,000 Family	\$5,000 Individual, \$10,000 Family Combined with Medical	\$4,500 Individual, \$9,000 Family Combined with Medical
Deductible - Drug	N/A	N/A	N/A	N/A	N/A	N/A	N/A	\$50 Drug	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Max. out-of-Pocket Medical	\$1,250 Individual, \$2,500 Family	\$1,500 Individual, \$3,000 Family	\$1,000 Individual, \$2,000 Family	\$3,000 Individual, \$6,000 Family	\$4,500 Individual, \$9,000 Family	\$3,500 Individual, \$7,000 Family	\$4,000 Individual, \$8,000 Family	\$3,000 Individual, \$6,000 Family	\$4,000 Individual, \$8,000 Family	\$6,350 Individual, \$12,700 Family	\$6,350 Individual, \$12,700 Family	\$6,250 Individual, \$12,500 Family	\$6,250 Individual, \$12,500 Family	\$5,000 Individual, \$10,000 Family	\$6,350 Individual, \$12,700 Family	\$6,250 Individual, \$12,500 Family
Max. out-of-Pocket Drug	N/A	N/A	N/A	N/A	N/A	N/A	\$500 Individual, \$1,000 Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

SOURCE: HealthSource RI

Firm-Specific Population: Subsidy Eligibility

Table 13 shows, of the total uninsured population, Rhode Island has the second-highest percentage of uninsured, subsidy-eligible employees in large/mixed firms¹⁷ in the New England region who may qualify for premiums through the exchange. While the state's uninsured population rate of 14.9 percent for these firms is lower than the national average of 15.4 percent, the most recent research available on the uninsured in relation to firm-specific employment shows that Rhode Island's percentage is higher than every New England state except Maine.¹⁸

	Total Uninsured	% of State Pop	Large / Mixed Firm	Employees as % of State Uninsured Pop	Small Firm	Employees as % of State Uninsured Pop	Self- or part-time, no employ.	Employees as % of State Uninsured Pop
United States	43,276	16.8%	6,676	15.4%	7,054	16.3%	3,675	8.5%
Connecticut	305	10.4%	38	12.5%	48	15.7%	40	13.2%
Maine	133	11.6%	24	18.1%	29	21.6%	19	14.4%
Massachusetts	160	2.9%	22	13.5%	19	11.7%	19	12.1%
New Hampshire	149	12.6%	22	14.8%	28	18.7%	15	10.4%
Rhode Island	116	12.4%	17	14.9%	23	19.5%	11	9.4%
Vermont	73	13.0%	9	12.2%	15	20.2%	9	12.4%

SOURCE: Robert Wood Johnson Foundation & Urban Institute, "How Would States be Affected by Health Reform", January 2010

Exchange Financing and Insurer Solvency

The Cost of Running the Exchange

Through various federal grants,¹⁹ \$83.8 million was allocated to finance exchange start-up costs. By 2015, each state exchange is expected to become sustainable, without continued federal assistance. In Rhode Island, the amount allocated for FY 2015 will likely first be proposed by the governor, then passed by the legislature, identical to the budget process for existing Rhode Island state agencies. State officials estimate the annual cost of running the state exchange to be between \$17.9 and \$23.9 million, with a portion of the cost determined by the amount of calls placed to the contact center. Next year, state officials (the contract is held by HSRI, the Executive Office of Health and Human Services, and the Office of the Health Insurance Commissioner) have the option to move to a cost-per-call payment plan, after paying the initial 2014 start-up cost. Other projected costs include maintenance and operation costs, employee salaries, legal counsel, actuaries, IT, data reporting, and annual advertisement campaigns accompanying the annual exchange enrollment period. Payment options are still being discussed, as the following section details.

Of the money Rhode Island has received, HSRI and SHOP have spent \$69.6 million (including expenditures and encumbrances) on the calling center, consulting work, IT framework, IT updates, and a marketing campaign, which will be continued on an annual basis. The remaining \$12.8 million will go toward the calling center and other IT work. A request has been sent to the federal government for more IT system funding.

Rhode Island is also part of a consortium participating in the "Enroll UX 2014" project, a public-private partnership creating design standards for statewide exchanges. Its IT upgrade was performed in conjunction with IT upgrades for state Medicaid and TANF systems. Operations and IT infrastructure, as well as consumer support, project evaluation, and staffing are slated for completion by the end of 2013. Remaining non-IT projects supporting exchange operations will be ongoing, prioritizing monitoring and data collection in order to improve functionality.

¹⁷ Large firms are those with over 100 employees.

¹⁸ "How Would States be Affected by Health Reform." The Robert Wood Johnson Foundation and the Urban Institute, January 2010.

¹⁹ Please see the Appendix for a breakdown of HSRI funding.

Long-Term Funding Options

HSRI has several options for generating revenue to support its operations, shown in table 14:

- A premium surcharge levied on the consumer (within the exchange) that is set at a percent of the premium;
- A user fee that is a flat rate charged to exchange participants;
- A premium assessment on all individuals obtaining insurance, within and outside of the exchange;
- A carrier tax on participant insurers on gross or net premiums or on profits;
- A claims-paid tax on participant insurers based on services rendered to individuals covered by the insurance carrier; or
- A broad-based tax on consumers or specific allocation of general state revenue,²⁰ in which general state revenue pays for a portion of HSRI’s operating costs.

Federal regulations released by the Dept. of Health and Human Services in 2012 determined that federal exchanges will be funded through a premium surcharge,²¹ capped at 3.5 percent of monthly premiums.²² Table 15 shows state decisions regarding self-sustaining funding as of October 2013.²³ California, Colorado, Idaho, Minnesota, Nevada, and Oregon, will fund their exchanges through a premium surcharge on the plans offered within the exchange. Meanwhile, Connecticut has agreed to assess fees on all individuals obtaining insurance, regardless of whether or not they purchase insurance through the exchange. Utah has agreed to charge a flat user fee of \$43 per month to exchange participants, and Washington has agreed to charge all carriers a carrier tax of 2.0 percent. Meanwhile, Maryland and Vermont will use unrelated, broad-based taxes already in place to cover the cost.

Table 14
Types of Assessments within State Exchanges

Type of Fee	Definition
Premium Surcharge	Additional cost to the premium for exchange consumers, set at a percent of the premium.
User Fee	A flat fee required to participate on the exchange.
Premium Assessment	A fee imposed on everyone within the health insurance market, except for self-insured companies.
Carrier Tax	A tax on participant insurers on gross or net premiums or on profits.
Claims-Paid Tax	A tax on participant insurers based on actual services rendered to individuals, with payment covered by the insurance carrier.
Broad-Based Tax	Use of a different tax, applicable to all individuals within the state. Certain states have used this option in combination with those above.
General Revenue Allocation	Allocation of funding from the state's general revenue funds.

Table 15

Type of Sustainable Financing	State Decision
Premium Surcharge	CA, CO, ID MN, NV, OR
Premium Assessment	CT
User Fee	UT
Carrier Tax	WA
Existing State Assessment or Tax	MD, VT
Undecided	DC, HI, KY, MA NY, NM, RI

SOURCE: The Commonwealth Fund

Rhode Island is one of six states in addition to the District of Columbia that is currently undecided, as table 15 shows. HSRI could use any of the options mentioned above, or any of the fees in combination with a separate broad-based tax or general revenue allocation. Colorado, Utah, and Nevada have agreed to use such hybrid approaches. Utah will appropriate \$615,000 in general revenue funds every year toward its exchange, in addition to its user fee. Colorado will

²⁰ The Executive Order creating HSRI stipulates that none of the state’s general revenue funds can be used for the start-up or maintenance of HSRI. However, legislators could change this provision with new legislation in the next legislative session.

²¹ “HHS Releases Insurance Exchange Rules, Includes Controversial Surcharges.” *Kaiser Health News*, December 2012.

²² “Seven States’ Actions to Establish Exchanges under the Patient Protection and Affordable Care Act.” The Urban Institute, April 2013.

²³ “Many States Undecided on Long Term Revenue Sources for the Exchange.” The Commonwealth Fund, July 2013.

rely on money from an unclaimed property tax fund in addition to its premium surcharge, while Nevada will rely on a mix of revenue from advertisement allowed on its web site, use of general revenue funds, and its premium surcharge.

Accounting for Increased Demand in Health Care

Throughout the formation of HSRI, exchange leadership worked closely with Rhode Island's Office of the Health Insurance Commissioner (OHIC), to evaluate insurer solvency. The OHIC, created in 2004, is the only state office solely focused on health insurance in the United States. Its experience in reviewing insurance company rates and their solvency played a large role in the creation of HSRI's rates.

Additionally, transitional federal risk adjustment and reinsurance programs established by the ACA were created to ease the transition to exchange marketplaces. The goal of the programs is to minimize adverse selection, offsetting the cost of high-risk patients in the individual market. The risk adjustment program, permanently in place, will involve carriers within the state compensating other carriers within the state based on demographics covered. This means that insurance carriers covering more lower-risk individuals and families will pay money to the Department of Health and Human Services (HHS), which will then reimburse carriers covering a disproportionate share of high-risk consumers. Additionally, the reinsurance program (in effect from January 1st, 2014 to December 31st, 2016) will reimburse carriers that cover individuals and families with significantly high claims. Reinsurance contributions will be \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016.²⁴

With 70,000 to 100,000 individuals expected to obtain coverage through the exchange in 2014, HSRI leaders acknowledge there is some uncertainty regarding the characteristics of new enrollees, and they will closely track the type of care obtained by the newly insured. However, because of the actuarial analysis involved in the creation of premiums, the experience offered by the OHIC, and the transitional risk adjustment and reinsurance program operated by HHS, HSRI premiums are expected to cover the cost of HSRI without negatively impacting the insurance carriers' reserves.

HSRI: Summary of Status

HSRI has made progress from its establishment by executive order in 2010, becoming a fully operating entity and enrolling thousands of individuals for health insurance coverage. The intent of the exchange is to increase the transparency of premium rates and the cost of claims, increase the pool of those insured, and gradually decrease the cost of insurance while improving health outcomes over the long run. HSRI has met the first of these goals; by publishing comprehensive rate sheets, HSRI has made its process transparent, easing rate comparisons to other New England states. However, while progress has been made, critical decisions have yet to be discussed. These decisions will determine the sustainability and effectiveness of HSRI for years to come.

²⁴ As defined by an ACA statute. Centers for Medicaid and Medicare Services, July 2012.

Considerations for Implementation

The marketplaces established by the ACA represent a shift in the way in which individuals will be able to access health care in Rhode Island. By making HSRI accessible to individuals earning between 100.00 and 400.0 percent of the Federal Poverty Line (FPL) and offering subsidies to those purchasing insurance online, the ACA's marketplaces intend to offer transparent structures to expand healthcare, make it more affordable, and make its costs predictable in the long-run. Besides creating affordable rates overall in the marketplace, government subsidies aim to offer further relief for the populations the exchange is trying to reach. Additionally, federal programs like the Risk Adjustment and Reinsurance program intend to ease the gradual transition to the larger risk pool the online marketplaces expect to create.

In Rhode Island, HSRI has made progress by:

- Creating rates and deductibles comparable to plans outside of the exchange;
- Increasing transparency with comprehensive rate sheets;
- Operating with minimal technical glitches in comparison to the federally-operated exchanges; and
- Signing up thousands for coverage within the first three weeks.²⁵

Factors for Further Examination

However, while the marketplace has demonstrated initial success in allowing customers to purchase plans, the exchange's impact once coverage is active in January 2014 is still unknown. As the marketplace moves into 2014 and beyond, four areas will be critical in determining HSRI's success. First, eligibility for SHOP is currently limited to 50 FTEs. Changing the definition before federal law requires it in 2016 could impact the state in different ways—by either expanding the pool in a shorter amount of time and impacting exchange insurance cost at a faster pace, or burdening the exchange with adverse selection issues attributed to a disproportionate enrollment of companies with poor experience ratings. The following section details these considerations.

In addition, HSRI must be codified into law in the upcoming legislative session, as the legal ability of the governor to create a revenue source for exchange maintenance through executive order has yet to be determined. Throughout the legalization process, the governor and legislators could reflect upon and determine which structure best serves Rhode Island; their decision could take into account many variables, as this report will discuss. Also, the legislature and governor must consider sustainable funding mechanisms for HSRI, as the following section will describe. Rhode Island's size and the scale of the exchange will potentially complicate measures to sustainably fund HSRI. Finally, publicly articulating intended outcomes with transparent performance measurement methodology will enable people to determine HSRI's success moving in the long- and short-term. This means determining the distribution of Medicaid and private insurance (HSRI) enrollment in the publicly released exchange enrollment numbers, and determining what these numbers mean in terms of the exchange's success.

²⁵ As of November 2, 2013: 4,642 individuals and families signed up for insurance through the online HSRI portal. Of these enrollees, 3,213 signed up for Medicaid, 1,192 individuals/families and 471 small businesses signed up for private insurance through HSRI.

Eligibility Requirements

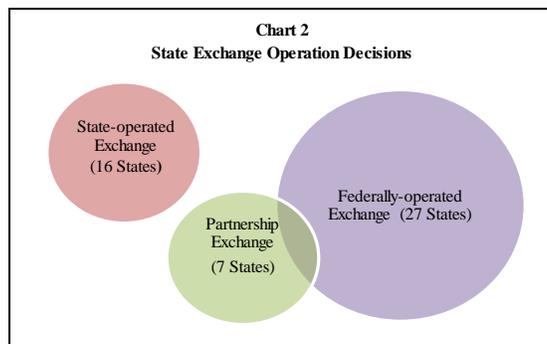
Further questions should be considered regarding potential SHOP expansion in advance of the federal law’s automatic expansion in 2016. The Rhode Island target population that is expected to purchase health insurance through SHOP, as a component of the larger statewide health benefit exchange, may or may not benefit from the increased access to affordable and potentially more innovative plans. While expanding the exchange to a larger pool of consumers (firms with 50-100 Full Time Employees, or FTEs) could make the exchange more economically viable, it also has the potential to result in adverse selection due to existing law surrounding firm experience ratings.

For instance, firms with more than 50 employees, or those subject to the employer mandate to provide affordable health insurance in 2015, are the same populations currently excluded from the benefits of SHOP in Rhode Island (see table 9). More specifically, Rhode Island’s current definition of “small group”, which is exclusive to small businesses with 50 or less FTEs, and the subsequent exclusion of firms with 50-100 employees, contrasts with the federal legislation. Firms with 50-100 FTEs represent 2.0 percent of the state’s businesses and employ 11.6 percent of the workforce in Rhode Island. Extending SHOP eligibility to these companies could mean expanding the SHOP population and lowering potential user fees or maintenance costs, which could serve to increase exchange viability when it becomes a self-sustaining operation.

Alternatively, since firms with greater than 50 FTEs are currently assessed using an experience rating, expanding the definition could attract a disproportionate share of businesses carrying relatively poor experience ratings (as the exchange does not assess experience ratings).²⁶ Companies with poorer experience ratings are assumed to carry a higher risk and likely higher health care costs. Meanwhile, companies with quality experience ratings may be incentivized to remain with their current, likely lower-cost plan outside of the exchange, leading to adverse selection within the SHOP marketplace and increased healthcare costs for this population. Thus, prior to changing the statute in advance of federal law, more questions about this potential definitional change should be examined.

Codification into Law

Another area of consideration is HSRI’s codification into law in the upcoming legislative session. Chart 2 shows state decisions regarding operation of the exchange— 16 states have chosen a state-operated exchange, seven states have chosen a partnership exchange (jointly operated with the federal government), and 27 states have defaulted to a federally-operated exchange. While HSRI is currently a completely public entity within the Department of Administration, its shape could change in the process of becoming an entity through the legislative process, rather than executive order. For sustainability purposes, the legislature will likely need to pass permanent legislation establishing HSRI’s existence, shifting the entity’s establishment from executive order to state law. Table 16 shows the exchange structure other



²⁶ Experience ratings are based on costs incurred in the years the business has been on a specific health plan. Lower costs incurred typically translate into a better experience rating. <http://cga.ct.gov/2008/rpt/2008-R-0377.htm>

states have chosen. Of the 16²⁷ states that have declared the construction of a state-based exchange, most are quasi-governmental agencies. Rhode Island has been joined by Kentucky, New York, and Vermont as states that will operate their own exchange within state government. An advisory board structure, as in Rhode Island, is the prevailing mode of governance among these states.

In the coming legislative session, leaders must ask:

- Is there a requirement for legislative exchange for the exchange? Or can the exchange continue to exist under executive order?
- A source of revenue for sustainable funding of the exchange will need to be established — can creation of a revenue stream be legally accomplished through executive order?
- What governmental shape and structure will HSRI take? In the long-term, will it exist as a quasi-public, public, or private entity?
- Which organizational structure best serves exchange participants and consumers in Rhode Island, and which organizational structure is most fiscally sustainable?

State	Government Decision	Structure	Governance
California	Legislation Enacted	Quasi-governmental	5-member Board
Colorado	Legislation Enacted	Quasi-governmental	12-member Board
Connecticut	Legislation Enacted	Quasi-governmental	14-member Board
Hawaii	Legislation Enacted	Non-profit	15-member Board
Idaho	Legislation Enacted	Quasi-governmental	19-member Board
Kentucky	Executive Authority	Operated by State	11-member Board
Maryland	Legislation Enacted	Quasi-governmental	9-member Board
Massachusetts	Legislation Enacted	Quasi-governmental	11-member Board
Minnesota	Legislation Enacted	Quasi-governmental	7-member Board
Nevada	Legislation Enacted	Quasi-governmental	10-member Board
New Mexico	Legislation Enacted	Quasi-governmental	10-member Board
New York	Executive Authority	Operated by State	5 Regional Advisory Committees
Oregon	Legislation Enacted	Quasi-governmental	9-member Board
Rhode Island	Executive Authority	Operated by State	13-member Board
Vermont	Legislation Enacted	Operated by State	5-member Board
Washington	Legislation Enacted	Quasi-governmental	11-member Board

Source: Kaiser Family Foundation, Establish Health Insurance Exchanges: An Overview of State Efforts; Kaiser Family Foundation: State Decisions for Creating Health Insurance Marketplaces; and Center on Budget and Policy Priorities, Status of State Health Insurance Exchange Implementation.

Making the Exchange Sustainable

On January 1, 2015, states are to be held responsible for all costs associated with the exchange, including operating and maintenance costs. With annual costs estimated between \$17.9 and \$23.9 million, limiting HSRI’s revenue stream to rate payers within the exchange could potentially create a narrow pool of consumers responsible for high premium payments.²⁸ Blue Cross Blue Shield of Rhode Island estimates that exchange maintenance fees will cost individuals an additional \$15 per person, per month, in the individual/family marketplace, and an additional \$22 per person, per month, in SHOP (additional costs are on top of monthly premium fees).²⁹ The impact of increased competition on rates as a result of Tufts Health Plan joining HSRI in 2015 has yet to be seen. Leaders in Rhode Island should comprehensively explore all potential funding mechanisms (see table 12). These options, whether implemented separately or as part of a hybrid approach, could expand HSRI’s revenue base and potentially decrease the burden of premiums on rate payers. However, such broad-based financing expansion, inclusive

²⁷ This number includes Idaho and New Mexico. These states originally planned for state operation, but are currently under partial federal operation due to time constraints.

²⁸ HSRI has requested \$26 million for FY2015, which includes remaining start-up costs. The estimated annual maintenance cost of \$17.9-\$23.9 million does not include the remaining start-up costs expected to be spent in FY2015.

²⁹ “Health Care Costs, New Rules, and New Benefits Lead to Higher Premiums,” and “More Healthcare and New Taxes Escalate Small Group Employer Premiums,” BCBSRI, April 2013.

of all taxpayers and the entire insurance community, potentially complicates the desired transparency and equity of HSRI's revenue-generating system.

The exchange's sustainable funding will most likely be discussed in the 2014 legislative session, with the establishment of the FY 2015 budget. A framework of revenue principles may serve as a guide when funding is discussed. In short, a high-quality revenue system:

1. Comprises elements that are complementary, including the finances of both state and local governments;
2. Produces revenue in a reliable manner. Reliability involves stability, certainty, and sufficiency;
3. Relies on a balanced variety of revenue sources;
4. Treats individuals equitably. Minimum requirements of an equitable system are that it imposes similar tax burdens on people in similar circumstances, that it is minimally regressive, and that it minimizes taxes on low-income individuals;
5. Facilitates taxpayer compliance. It is easy to understand and minimizes compliance costs;
6. Promotes fair, efficient and effective administration. It is simply and professionally administered, raises revenue efficiently, and is applied uniformly;
7. Is responsive to interstate and international economic competition;
8. Minimizes its involvement in spending decisions and makes any such involvement explicit; and
9. Is accountable to taxpayers and rate payers.

More specifically, leadership could consider the following questions regarding maximizing efficiency and creating a sustainable funding system for the HSRI and SHOP:

- Should HSRI be self-sustaining (generating revenue strictly from within, only among rate-payers)?
- Should the insured, self-insured, and exchange consumers take part in broadly paying for the system as a whole?
- Which method will maximize transparency, the premium surcharge, user fee, or claims paid/insurance-based funding mechanisms? (See table 14).
- Should local or state revenue be used?

Considering Funding Options

As mentioned in table 14, there are several options for long-term exchange financing. The intent of a premium surcharge, to be leveraged on consumers strictly within the exchange—the option currently used by six states—is for consumers to be able to easily identify the cost of the plan, and the additional cost to support HSRI (as long as the surcharge is shown separately). Similarly, a user fee would be a transparent funding mechanism, as consumers would directly pay the cost of maintaining the exchange in a separate, tangible fee. Alternatively, a carrier tax or claims-paid tax on participant insurers offer the potential for both transparent and less transparent options, depending on their presentation to consumers. If the carrier or claims-paid tax is transferred to the consumer in the form of overall higher premium costs, such a method would be significantly less transparent, as consumers would not directly be paying the cost of the exchange. However, if the carriers identify the portion of the premium going toward payment of the carrier or claims-paid tax, the option would retain its transparency.

Additionally, a premium assessment on individuals within and outside of the exchange may be inequitable, as those paying for the exchange may not have opted to use the exchange or the exchange’s amenities, like the contact center. The state could also consider allocating general revenue funding, or the imposition of a new broad-based tax, to contribute to HSRI. However, while allocating general revenue funds would offer an immediate stream of funding to HSRI, it would require alternative decisions regarding use of funds in the state’s budget.

Articulating and Measuring the Exchange’s Success

State leaders could consider the following questions when addressing the public: what will success look like on the exchange? How will success be defined?

Publicly articulating intended outcomes with specified performance measures could offer a transparent way for the public to track HSRI’s progress. Establishing specific, publicly-stated goals that identify the desired percent insured, annual cost, and health outcomes in the near- and long-term future could offer perspective when determining exchange success. For example, what does increased premium predictability, transparency, and stabilization of health insurance premiums look like? Publicly offering areas to measure and how they will be measured will serve an important role in determining HSRI’s impact on Rhode Island. Also, deciding which entity will store, oversee, organize, and maintain the data collections used for outcome measures will be crucial to determining HSRI’s success measurement parameters. Coming to a consensus on the definition and measurement of success will represent a clear step in progress as the exchange develops.

Breaking Down the Numbers: Medicaid vs. HSRI Enrollment

As of November 2, 2013, 4,405 individuals and families signed up for insurance through HSRI. However, this number includes the four types of individuals who may sign up for insurance through the online portal on the HSRI web site. As table 17 shows, this includes those who are:

- Enrolling for private insurance within HSRI and are subsidy-eligible;
- Enrolling for private insurance within HSRI and are ineligible for subsidies;
- Enrolling in Medicaid (newly eligible); and
- Enrolling in Medicaid (were eligible for Medicaid before the ACA, but are just now signing up for coverage).

Insurance Type	Online Enrollment Type	Enrollee Type	Income (% FPL)	Cost Breakdown
<i>Private</i>	HSRI	Subsidy-eligible	100.0 - 400.0% FPL	Self-sustaining cost (\$17-24 million) + Federal Subsidies
	HSRI	Subsidy-ineligible	400.0% FPL+	Self-sustaining cost (\$17-24 million)
<i>Public</i>	Medicaid	Newly eligible (No Children)	0.0- 138.0% FPL	Federally covered, with state contribution gradually increasing from 0.0 in 2014 to 10.0 percent in 2020
	Medicaid	Already eligible; Newly enrolled (Pregnant Women, Children, Parents)	0.0 - 100.0% FPL	Additional cost to state (State pays about 50.0 percent of the cost of those already eligible for Medicaid in Ritecare)

The two types of HSRI enrollees are signing up online for private insurance, and are electing to choose their insurance from a spectrum of 12 to 16 plans (depending on individual/family marketplace or SHOP registration). In contrast, Medicaid enrollment through the online HSRI portal features a single, publicly paid-for plan on RItE Care, Rhode Island's Medicaid program.

Of the 4,405 individuals who have signed up for insurance through HSRI, 72.9 percent (3,213) signed up for the state's Medicaid (both newly eligible and previously eligible). In contrast, 27.0 percent (1,192) of enrollees signed up for private insurance through the exchange (HSRI). A total of 471 small businesses have also opened accounts, but are not included in the enrollment numbers. Moreover, a review of health benefit exchanges in selected state-operated marketplaces nationwide has found that a majority of sign-ups within total exchange enrollment numbers reported have been for Medicaid.³⁰

The implications of this data are important, as the number of Medicaid enrollees has different financial consequences for the state than the number of exchange enrollees. For example, while the cost of newly eligible Medicaid enrollees (those between 0.0 to 138.0 percent FPL and without children) will be covered by the federal government in 2014 (with state contributions rising to 10.0 percent in 2020), new Medicaid sign-ups among individuals previously eligible (0.0 to 100.0 percent FPL and are pregnant, children, or parents) will immediately increase Medicaid costs for the state. Because the Federal Medical Assistance Percentage (FMAP) is about 50.0 percent, Rhode Island contributes 50.0 percent (with a 50.0 percent federal match) toward healthcare for those already eligible for Medicaid. Thus, an increase in this type of enrollee will require a higher total state contribution toward Medicaid costs, beginning in 2014. An increase in newly eligible enrollees will gradually increase state costs over time. The distribution of newly eligible and previously eligible enrollees has not yet been indicated. This allocation will be important as policymakers consider the short-term and out-year budget implications of HSRI.

HSRI was established to foster competition and offer an array of choices in a transparent, consumer-driven marketplace. The proportion of individuals signing up for private insurance must be evaluated to effectively capture exchange participation and its potential state financial implications.

Summary of Considerations

As the effective coverage date approaches, HSRI leaders could consider the following:

- The implications of expanding the eligibility requirements to include businesses with 50-100 FTEs before the federally mandated eligibility expansion in 2016;
- Reflecting upon the exchange's organizational structure and identifying the structure best suited to Rhode Islanders when codifying HSRI into law, as the legal capability of the governor to establish a sustainable funding mechanism for the exchange through executive order has yet to be determined;
- Reviewing funding mechanisms for sustainability funding that reflects Rhode Island's values and priorities in the coming years to become self-sustaining by 2015;
- Publicly articulating intended outcomes with specified performance measures for transparency in determining HSRI's short- and long-term success; and
- Evaluating the distribution of HSRI's enrollment numbers (Medicaid vs. HSRI) in terms of the state and HSRI's financial outlook.

³⁰ "In first month, the vast majority of Obamacare sign-ups are in Medicaid." *The Washington Post*, November 1, 2013.

Appendix

I. Current HSRI Funding Sources

The \$83.8 million startup and initial operating costs for HSRI have been secured for the marketplace to run through the end of 2014. By January 1, 2015, HSRI must be self-sustaining, either through state funding or rate pricing. The current funding was secured by the following grants, as shown in table 18:

- **State Planning Grant:** In September 2010, HSRI (known as the Health Benefits Exchange at that time), received \$1.0 million in the form of a State Planning Grant, administered by the Office of the Health Insurance Commissioner.
- **Grant Level One:** In March 2011, Rhode Island received \$5.2 million in federal funding, administered by the Rhode Island Department of Business Regulation, to strengthen IT systems and scale of the exchange marketplace. In January and April of 2013, Rhode Island applied for and secured supplemental funding of \$1.3 and \$9.8 million, respectively.
- **Grant Level Two:** In November 2011, Rhode Island received \$58.5 million in federal funding, administered by the Rhode Island Department of Business Regulation to build capacity and infrastructure in numerous areas, led by Medicaid and the exchange leadership. In January of 2013, Rhode Island applied for and secured supplemental funding of about \$8.0 million.
- **Early Innovator Grant:** Rhode Island is part of a multi-state consortia proposal with \$35.6 million in funding, spearheaded by the University of Massachusetts Medical School, including Maine, Massachusetts, Rhode Island, and Vermont; this funding does not appear in table 18.

Grant	Date	Amount
State Planning	Sep-10	\$1.0
Grant Level One	May-11	5.2
Supplement	Jan-13	1.3
Supplement	Apr-13	9.8
Grant Level Two	Nov-11	58.5
Supplement	Jan-13	8.0
<i>Total</i>		<i>\$83.80</i>
<small>*Does not include the Early Innovator Grant, awarded to the University of Massachusetts Medical School for a multi-state consortia, which includes Connecticut, Maine, Massachusetts, Rhode Island, and Vermont</small>		
<small>SOURCE: Centers for Medicare & Medicaid Services</small>		

II. Comparison of Similar Blue Cross Blue Shield Plans across New England: Gold and Bronze Categories

Figures 11-14 show premiums and deductibles for similar BCBS plans across New England in the Bronze category. Figures 15-18 show premiums and deductibles for similar BCBS plans across New England in the Gold category.

