Rhode Island's Health Benefit Exchange: Progress and Challenges

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RIPEC

Executive Summary

A central focus of the Patient Protection and Affordable Care Act (ACA), passed in 2010, is to reduce the number of uninsured Americans. Beginning on January 1, 2014, the state-based Health Benefits Exchanges (exchanges) further this goal by providing access and a competitive marketplace for individual and small business plan purchasing. This report is intended to update policymakers and the public about national and state-level progress in developing state-based exchanges. The ACA includes a number of additional interdependent provisions to further reduce the uninsured population, including:

- An individual mandate requiring U.S. citizens and legal residents to maintain health care coverage;
- Expanding Medicaid eligibility to include individuals with incomes up to 138 percent of the federal poverty level (FPL);
- Federal subsidies to assist qualified individuals and small business owners in obtaining coverage;
- Employer penalties for large companies that do not provide adequate, affordable health care coverage for their workers; and
- Changes to private health insurance, including new minimum standards for coverage.

The individual mandate may stabilize premiums by increasing the number of policies held by relatively healthy people who are currently uninsured. Specifically, the larger the pool of healthy individuals, the lower the risk, which may, in turn, stabilize premiums. Similarly, new, lower-cost policies may become available to individuals and small businesses through exchanges, also helping to broaden the risk pool. It is expected that this will also help offset costs associated with minimum coverage standards.

In order to help facilitate compliance with the individual and employer mandates, exchanges will serve as competitive marketplaces for individuals and small businesses to compare and purchase private health care plans. The ACA requires exchanges to serve individuals and families with incomes between 138 and 400 percent of FPL who are ineligible for Medicaid or other federal programs and without access to affordable, employer-based health insurance.

By the end of the year, states must decide to establish and operate their own exchange or partner with the federal government. This decision requires resolute policy related to implementation, including contracts with health plans, technological infrastructure, and state legislation. Exchanges must be administered by a state government or non-profit entity, and are to be responsible for ensuring that available private health insurance plans meet federal standards. The federal law requires states to create a Small Business Health Options Program (SHOP) exchange to assist small businesses (with fewer than 100 employees) in enrolling their employees into health plans in the small group market. Currently, Rhode Island's law permits small businesses with up to 50 employees to participate in SHOP, though this may be subject to change in accordance with federal legislation.

To date, 18 states and DC, including Rhode Island, intend to establish state-based exchanges. Seven states will partner with the federal government to facilitate an exchange. States unable or unwilling to establish an exchange to begin functioning by January 2014 are to automatically default to a federal system. In either case, exchange enrollment will begin in October 2013. Table 1 shows state exchange decisions as of January 2013.

Table 1
State Exchange Decisions

Option	Number of States
State-Based Exchange	19*
Federal Partnership	7
Default to Federal	25

*Including DC

Source: Kaiser Family Foundation, Establish Health Insurance Exchanges: An Overview of State Efforts, January 2013

Progress in Rhode Island

Governor Lincoln Chafee signed an executive order on September 19, 2011, establishing the Rhode Island Health Benefits Exchange (RIHBE) as a division within the Executive Department, and in December 2012 the federal government gave Rhode Island conditional approval for its state-run exchange. The RIHBE has received funding from three federal grant sources and one private source totaling $64.8 million. These resources give Rhode Island the opportunity to construct a portal intended to deliver streamlined and cost-effective service once the exchange is up and running.

A 13-member Exchange Advisory Board will use public input to make recommendations to the Exchange Director for the construction of the exchange. The state was required to submit an "Exchange Blueprint" by December 14, and the federal government was required to issue conditional approval by January 1, 2013. Rhode Island was granted conditional approval in December 2012. In accordance with federal guidelines, eligible Rhode Islanders will begin enrolling on October 1, 2013, for coverage effective by the January 1, 2014 federal deadline. The Advisory Board will work with the existing working groups of the Rhode Island Healthcare Reform Commission.

Chart 1
State-based Health Insurance Exchange Timeline

SOURCE: Kaiser Family Foundation, "Establishing Health Insurance Exchanges: An Overview of State Efforts", November 2012

Developers of the RIHBE have moved forward with several broad areas of work in anticipation of the January 2014 deadline. Through the Unified Health Infrastructure Project, the state will create an integrated system to determine eligibility for Medicaid, the exchange, and eventually other public programs. Additional projects include the development of infrastructure for governance and staffing, evaluation and reporting, plan management, financial management, and consumer support.

Governor Chafee acknowledged the ACA requirement of a self-sustaining exchange in his Executive Order. Exchange developers are required to find long-term funding opportunities that do not rely on state general revenues. The RIHBE also seeks to leverage opportunities with partner states in the New England Collaborative, the largest and most developed multi-state exchange collaborative in the country.[1]

Challenge to Constitutionality

In late March 2012, the United States Supreme Court heard oral arguments for the *United States Department of Health and Human Services vs. Florida*, challenging the constitutionality of several components of the ACA. Specifically, the case explored the constitutionality of state Medicaid expansion and the penalty associated with the individual mandate to purchase insurance. Opponents of the mandate argued the required purchase of a private good to be unconstitutional, while supporters defended the mandate as a tool to regulate interstate commerce. Supporters also contended that the mandate plays an important role in stabilizing insurance markets and reducing premiums, two key goals of the ACA.

In late June 2012, the Supreme Court upheld the individual mandate, as well as the bulk of Medicaid expansion. However, the Supreme Court also held that the federal government cannot punish states opposing Medicaid expansion by withholding all federal Medicaid funds. Additionally, the penalty for defying the individual mandate was recognized as a tax by the Court.

The Supreme Court upholding the constitutionality of ACA provisions allowed Rhode Island's progress with Medicaid expansion and the exchange to continue. Had the Supreme Court not upheld these ACA provisions, federal funding and state-level enrollment could have been jeopardized. The Supreme Court defined the individual mandate as a tax which could motivate the uninsured to purchase coverage. Higher enrollment in health insurance plans may help states realize savings, increasing purchasing power and broadening the pool of covered individuals. In addition, ACA-related expansion may reduce state-level spending – specifically, state contributions to uncompensated care costs and disproportionate share hospital expenses (DSH, sometimes referred to as "charity care").

[1] The New England States Collaborative for Insurance Exchange Systems (NESCIES), also known as the Massachusetts Early Innovator Cooperative Agreement, was formed for New England states to share technology and experience in creating health insurance exchanges.

Affordable Insurance Exchanges

The ACA directs states to design, develop, and implement exchanges to serve as a health insurance marketplace for individuals and small businesses. If states establish independent exchanges, legislatures must determine the form of governance: an existing government agency, a newly created government entity, or through a contract with a state-created non-profit entity. The exchanges must be fully operational by January 1, 2014, and self-sustaining by January 2015.

In May 2012, the United States Department of Health and Human Services (HHS) announced a series of exchange rules and guidance regarding establishing minimum federal standards for states operating exchanges, health insurance issuers, and employers participating in the Small Business Health Options Program (SHOP).[2] HHS also issued a Draft Blueprint for federal approval of state-based exchanges, and issued general guidance on Federally Facilitated Exchanges (FFEs). Combined, these documents support the implementation information in previously issued regulations by describing the structural and operational requirements for state exchanges, the approval process, and providing for FFEs.

Functions and Structure

The ACA specifies that an exchange must provide the following core functions:

- Certification, recertification and decertification of plans;
- Operation of a toll-free hotline and website to provide plan information;
- Assignment of a standardized price and quality rating to plans;
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs or exempt from the mandate;
- Provision of an electronic calculator to determine the actual cost of coverage; and
- Establishment of a navigator program that provides grants to entities assisting consumers.[3]

Exchange interfaces must also coordinate with established, or newly expanded, Medicaid programs in accordance with expanded Medicaid eligibility for childless adults at or below 138 percent of the FPL. In this way, an exchange portal will allow individuals to determine eligibility for Medicaid, CHIP, and federal subsidies for commercial coverage. The exchange will also offer tools to assess the affordability of employer-based plans and determine eligibility for subsidies.[4]

[2] National Council of State Legislatures. http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx#acabasic. Retrieved May 5, 2012.
[3] National Council of State Legislatures. http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx#acabasic. Retrieved May 5, 2012.
[4] *RI Health Benefit Exchange: Update for RI Business Group on Health.* http://www.ltgov.ri.gov/rihrc/exchange.php. Retrieved July 2, 2012.

Table 2 shows the exchange structure among states that have declared the construction of a state-based exchange. Of the 18 states that have declared the construction of a state-based exchange, most will be quasi-governmental. Rhode Island is joined by Kentucky, New York, Utah, 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.

Table 2
State Exchange Structures

State	Structure	Governance
California	Quasi-governmental	5-member Board
Colorado	Quasi-governmental	12-member Board
Connecticut	Quasi-governmental	14-member Board
Hawaii	Non-profit	15-member Board
Idaho	Not yet addressed	N/A
Kentucky	Operated by State	11-member Board
Maryland	Quasi-governmental	9-member Board
Massachusetts	Quasi-governmental	11-member Board
Minnesota	Not yet addressed	Not yet addressed
Mississippi	Non-profit	9-member Board
Nevada	Quasi-governmental	10-member Board
New Mexico	Quasi-governmental	10-member Board
New York	Operated by State	5 Regional Advisory Committees
Oregon	Quasi-governmental	9-member Board
Rhode Island	Operated by State	13-member Board
Utah	Operated by State	N/A
Vermont	Operated by State	5-member Board
Washington	Quasi-governmental	11-member Board

Source: Kaiser Family Foundation, Establish Health Insurance Exchanges: An Overview of State Efforts

Eligible Populations

Beyond the individual mandate, the ACA aims to expand access to coverage in three primary ways:

- Medicaid may be expanded to cover childless adults up to 138 percent of the FPL, depending on whether states opt in to this part of the law;
- Exchanges will offer qualified health plans to individuals in a competitive marketplace. In order to facilitate access, subsidies in the form of tax credits are available to people with incomes between 138 percent and 400 percent FPL.
- Employers with more than 50 employees will be required to provide a health insurance option, or will face a penalty. Companies will fewer than 100 employees will be able to purchase health insurance through the Small Business Health Options Program (SHOP), part of the HBE.[5]

Exchange enrollment will begin in October 2013, in advance of the January 2014 functional start-date, followed by annual open-enrollment seasons for those purchasing coverage through the exchange. Rhode Island is developing an advanced technological infrastructure to accommodate the new requirements. To raise awareness and expand enrollment participation, Rhode Island will partner with community organizations, and is working to simplify the enrollment process and communicate access to the newly eligible.

[5] According to national law, companies with up to 100 employees can enter SHOP. Rhode Island law currently allows companies with up to 50 employees to participate in SHOP. This may be subject to change in accordance with the federal law.

Medicaid Expansion

Estimates of the potentially insured population and subsequent costs vary based on the ultimate take-up rate of those who would be newly eligible through expanded Medicaid coverage, those previously eligible but unenrolled, and employers' response to offering coverage. Medicaid expansion populations will be matched by a higher federal rate, while those previously eligible who enroll will be reimbursed at current federal medical assistance percentage (FMAP) levels.

Although the take-up rate for the potential program is unknown, Medicaid expansion to 138 percent FPL and increased awareness for Medicaid enrollment could extend coverage to a large group of currently uninsured Rhode Islanders. The Rhode Island Healthcare Reform Commission estimates a total of 70,000 Rhode Islanders could gain coverage through Medicaid expansion, commercially through the exchange or through employer-sponsored coverage. The majority of the newly insured (40,610 person) would be covered through Medicaid in 2014.

According to data from the Urban Institute and Robert Wood Johnson Foundation, there are roughly 116,000 uninsured Rhode Islanders. Over a quarter of the state's uninsured population would qualify for Medicaid expansion through the ACA. Still another 13.0 percent of uninsured Rhode Islanders may be eligible, but unenrolled in Medicaid. Table 3 depicts these estimates of Rhode Islanders newly Medicaid eligible or previously eligible, but unenrolled.

Table 3
Potentially Medicaid-Eligible (Numbers in Thousands)

State	Total Uninsured	% of Pop	Newly eligible uninsured	% of Uninsured Pop	Currently eligible uninsured	% of Uninsured Pop
United States	43,276	16.8%	10,524	24.3%	9,819	22.7%
Connecticut	305	10.4%	78	25.6%	15	13.0%
Maine	133	11.6%	27	20.3%	15	11.6%
Massachusetts	160	2.9%	0	0%*	74	46.2%
New Hampshire	149	12.6%	33	22.5%	21	14.4%
Rhode Island	**116**	**12.4%**	**33**	**28.6%**	**15**	**13.0%**
Vermont	73	13.0%	0	0%*	25	35.1%

* Massachusetts and Vermont have enacted reforms that previously expanded coverage to this population

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

Overall, Rhode Island's uninsured rate of the total population, 12.4 percent, is the third lowest in New England and below the national rate of 16.8 percent. Rhode Island also has a high potential rate for enrollment in expanded Medicaid program to cover over a quarter of the state's uninsured with an enhanced FMAP. Of the New England states, Rhode Island's 28.6 percent of uninsured, childless adults at or below 138 percent FPL is

the highest in New England and above the national average of 24.3 percent. At 13.0 percent, Rhode Island and Connecticut both trail Maine for the lowest rate of currently Medicaid eligible, but uninsured residents. Enrolling this population in Medicaid would reduce the overall number of uninsured and would be matched at the current FMAP rate.

Subsidies

For qualified individuals between 138 and 400 percent FPL, the ACA allots federal subsidies toward the purchase of insurance through an exchange. Qualified individuals must meet the following characteristics:

- Lawful residence in a state in the United States, unless presence in the US is only for a specified period;
- Not enrolled under an exchange plan as an employee or an employee's dependent;
- Modified adjusted gross income of less than 400 percent FPL;
- Enrolled in an employer's qualified health benefit plan**,** a grandfathered plan (group or non-group), and ineligible for Medicaid, Medicare, military or veterans' coverage or other coverage recognized by the commissioner; and
- Not a full-time employee in a firm where the employer offers affordable health insurance and makes the required contribution toward that coverage.[6]

According to the estimates from the Robert Wood Johnson Foundation and the Urban Institute, almost 45.0 percent of uninsured Rhode Islanders may be eligible for subsidies. Subsidies, in the form of tax credits, could make health coverage more affordable in the exchange for these purchasers between 138 and 400 percent FPL. Making coverage more accessible and affordable to these Rhode Islanders would further broaden the base of insured Rhode Islanders, which may help stabilize premium costs.

Table 4
Potentially Subsidy-Eligible by Firm Size (Numbers in Thousands)

	Total Uninsured	% of Pop	Large / Mixed Firm	% of Uninsured Pop	Small Firm	% of Uninsured Pop	Self- or part-time, no employ.	% of 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

Estimates for currently uninsured Rhode Islanders eligible for subsidies or tax credits are shown in Table 4. The population estimates are based on income and type of employment that would dictate purchasing behavior. Currently, the state's RIte Share

[6] http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx#ehbs

program covers the cost of the employee's share and wraparound services for qualifying Rhode Islanders who cannot afford the available coverage. Exchange subsidies could also function in this capacity for individuals between 138 and 400 percent of the FPL.

Of the total uninsured population, Rhode Island has the second highest share of uninsured, subsidy-eligible employees in large/mixed firms who may qualify for premium subsidies through the exchange. The state's rate of 14.9 percent is lower than the national average of 15.4 percent, but higher than every New England state except Maine. Rhode Island's rate of uninsured, subsidy-eligible employees in small firms as a share of total uninsured – 19.5 percent – is the third highest in New England and exceeds the national average by 3.2 percent. Uninsured Rhode Islanders without access to coverage through full-time employment (or are self-employed) make up 9.4 percent of the total uninsured population, the lowest rate in New England.

Employer-Based Plans

Although most Americans currently rely on insurance through employer-based plans, the Employee Benefit Research Institute (EBRI) cites a decreasing number of workers with access to insurance since 2002, increasing the number of uninsured working Americans. The EBRI study defines two broad categories of uninsured American workers: those ineligible due to part-time status, and those who cannot afford premiums when coverage is offered. Unmentioned in the study are workers who voluntarily opt out of coverage. The study also found that employment rates do not influence employer coverage offerings.

Rhode Island-specific data from the Rhode Island Department of Labor and Training indicates a similar trend in the number of Rhode Islanders receiving health insurance through employers. In 2005 and 2007, 79.0 percent of Rhode Islanders accessed health insurance through their employers, compared to 73.0 percent in 2009 and 2011. The share of employer contribution to premium cost has also decreased between 2005 and 2011. Approximately a quarter of businesses paid the full cost of coverage in 2005, compared to less than 15.0 percent in 2011.

Employer Responsibility

There is no explicit employer mandate in the ACA. However, there are two instances when a business with more than 50 employees may be assessed a penalty:

- No coverage offered, and at least one full-time employee (FTE) (averaging at least 30 hours per week) receiving subsidized coverage through the exchange; or
- No affordable or adequate coverage offered, and at least one FTE (averaging at least 30 hours per week) receiving subsidized coverage through the exchange.

Under the conditions above, the employer penalty for not offering coverage is $2,000 annually per FTE. The penalty for not offering affordable or adequate coverage is an annual fee of $3,000 per FTE receiving a premium credit, with a maximum penalty equal to $2,000 per FTE. In both instances, the first 30 employees are exempted in this calculation. Businesses with fewer than 50 employees are exempt from these new policies. Table 5 breaks down Rhode Island businesses by the number of employees.

Table 5
Rhode Island Firms by Size

# 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

The majority of Rhode Island businesses, 96.2 percent, employ fewer than 50 workers. However, 59.6 percent of all Rhode Islanders in the workforce are employed at firms with 50 or more employees. Most Rhode Island businesses will, therefore, be exempt from any requirements associated with the ACA, though most Rhode Island employees work for companies that may have to seek compliance.

Rhode Island firms with fewer than 50 employees, 96.2 percent of all firms in the state, will be eligible to use the exchange to purchase affordable plans, benefitting from economies of scale and greater purchasing power. This accounts for 154,719 Rhode Island employees, or 40.4 percent of the state's workforce. Access to health insurance could improve worker health, and consequently, productivity. Further, exchange facilitation and increased activity in the healthcare field could result in more jobs statewide.

The ACA specifically supports small businesses in enrolling employees in employer-based plans through a health insurance tax credit for businesses with up to 25 employees. Intended to offset the cost of coverage, the tax credit could encourage small businesses to begin or continue offering health insurance to low- and moderate-wage employees. Further, any Rhode Island firm with fewer than 50 employees can enter into a SHOP exchange to purchase qualified health plans. By massing small business enrollment, employers leverage economies of scale that could reduce administrative plan costs per purchaser.

Since the individual mandate addresses uninsured consumers who opt out of coverage, exchanges will also offer lower-cost options to individuals and families who are not eligible for employer-based plans. Future participants in health plans offered through exchanges may include part-time workers who are not eligible for employer-based plans, as well as low-wage, full-time workers who opt to purchase insurance directly through an exchange rather than through their employer due to affordability considerations.

Essential Health Benefits

Whether acquiring insurance from the exchange or the private market, the ACA requires health plans to provide "Essential Health Benefits" (EHBs). EHBs must include the following provisions:

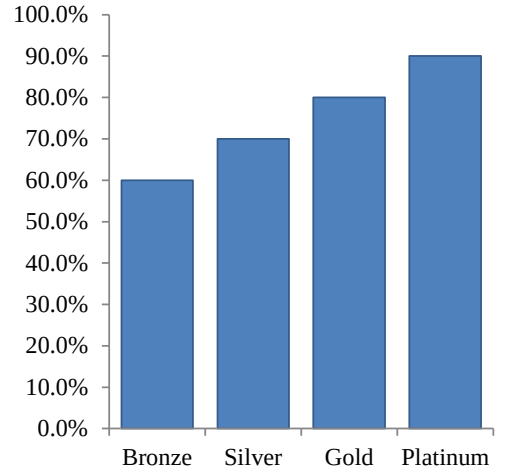
- Ambulatory, emergency, and hospital patient services;
- Maternity and newborn care, and pediatric services;
- Mental health, substance use, and behavioral health treatment;

- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services; and
- Preventive and wellness services and chronic disease management.[7]

Rhode Island identified Blue Cross & Blue Shield of Rhode Island's Vantage Blue small group plan as the state's benchmark plan covering EHBs. The state also included three supplemental benefits provided by other carriers. Pediatric dental services will be covered through age 19, pediatric vision care through age 19 will include vision materials, and some habilitative services (yet to be defined) will be supplemented from additional plans.[8]

Various levels of cost-sharing for coverage are tied to the EHBs requirements. These tiers range from bronze to platinum, depending on the percent of coverage assumed by the insurer, as shown in Chart 2. Insurers would, therefore, cover 60.0 percent of coverage costs for bronze purchasers, while insurers would cover 90.0 percent of the platinum level coverage. Platinum coverage would have the highest premiums, but lowest out-of-pocket costs. Premium tax credits for eligible consumers will be based on the silver level, or 70.0 percent coverage; therefore, consumers who opt for the platinum plan would be responsible for the difference in premium cost. However, the actuarial value is an estimate, and does not project the plan's actual costs to the consumer. For the consumer who opts for the platinum plan, lower out-of-pocket costs and deductibles for services may offset the higher premium costs.

Chart 2
Actuarial Value of Essential Benefits



The ACA requires plans at least at the silver and gold levels to be available within the exchange[9]. Individuals and small businesses could also access at least one of these tiers of coverage through the exchange in the form of Qualified Health Plans (QHP). Licensed by states and accounting for the aforementioned EHB requirements, QHPs will be subject to a specified list of requirements related to marketing, choice of providers, plan networks, essential benefits, and other features. Premiums for each tier of a QHP inside and outside of the exchange must be the same.

[7] National Council of State Legislatures. http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx#acabasic. Retrieved May 5, 2012.
[8] Rhode Island Health Coverage Project, "Essential Health Benefits: Rhode Island's Choice Under the Affordable Care Act", December 2012
[9] Excluding dental-only plans.

States must define the plan level that meets the required EHB in the exchange. The cost of the EHB plan compared to the cost of Medicaid for a newly eligible individual could influence the expansion decision for states. If the EHB for an individual payer proves more costly than Medicaid, states may seek to expand Medicaid to a larger pool to take advantage of enhanced FMAP. Once a state establishes a benchmark for the EHB plan, this value can be compared to the anticipated take-up rate among the newly Medicaid-eligible population to project future costs.

Creating the Exchange in Rhode Island

Rhode Island legislators did not pass proposed legislation creating a Rhode Island Exchange as a quasi-public agency during the 2011 legislative session, amid conflict about anti-abortion language.[10] Governor Chafee subsequently signed an executive order to establish the RIHBE, as a division within the Executive Department. Executive Order 11-09 also includes the establishment of an Exchange Advisory Board as the public stakeholder advisory group to make recommendations to the Director of the exchange, with former U.S. Attorney Margaret Curran named as chair and Donald Nokes, President and Co-Founder of NetCenergy, named as vice-chair[11]. Other members of the Advisory Board include:

- Steven Costantino, Secretary of Health and Human Services
- Michael Gerhardt, Retired Health Insurance Executive and Non-Profit Executive Director
- Linda Katz, The Economic Progress Institute
- Christopher Koller, Health Insurance Commissioner
- Richard Licht, Director of Administration
- Marta Martinez, Progresso Latino
- Margaret Holland McDuff, Family Service of Rhode Island
- Dr. Pamela McKnight, Non-practicing Neurologist
- Dwight McMillan, The Basics Group
- Tim Melia, UFCW Local 328

The Exchange Advisory Board will use public input to make design and policy recommendations for construction of the exchange, with the goal of enrolling eligible Rhode Islanders on October 1, 2013 for coverage effective by the federal deadline of January 1, 2014. The Advisory Board will work alongside the existing working groups of the Rhode Island Healthcare Reform Commission. The Governor's Executive Order authorizes the exchange to receive funds from insurers or other entities, including the United States Department of Health and Human Services. The Board will also determine the amounts and collection protocols for these funds.

[10] *RI Legislators Join Suite Against Health Exchange.* Providence Journal Bulletin, December 2011. http://news.providencejournal.com/politics/2011/12/28-ri-legislators-join-suit-against-health-exchange.html. Retrieved May 13, 2012.

[11] Mr. Nokes was replaced as Vice Chair by Geoff Grove, CEO of Pilgrim Screw in 2012.

In June 2012, Governor Chafee announced the selection of Christine C. Ferguson as the director of the RIHBE. As director, Ferguson will work with the Exchange Advisory Board to oversee design, development and operation of the exchange.

In addition to establishing the exchange and the Advisory Board, Executive Order 11-09 states that the state exchange:

- Must meet all minimum requirements set by the Affordable Care Act;
- May not engage in a conflict of interest: Board members cannot be affiliated with any insurer, agent, broker or provider;
- Allows for the establishment of advisory committees; and
- Contracts with carriers and determines which insurers are allowed to participate, given they meet the minimum federal requirements.

The RIHBE is part of the state's Unified Health Infrastructure Project, a multi-agency effort to transform and align statewide policy, operations and technology among the exchange, Medicaid, and human service programs in Rhode Island. The opportunity to coordinate these efforts may result in efficiencies related to coordination by streamlining efforts across departments.

Progress to Date

Information technology (IT) infrastructure is a crucial element of exchange functionality. Through advancing its IT infrastructure, the state will create an integrated eligibility system that determines qualification for federal health insurance subsidies through the exchange, Medicaid, and, eventually, other public programs. In April 2012, the exchange issued an RFP for vendors to design and administer the exchange and eligibility system. 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.

The exchange is moving forward with several additional projects, including governance and staffing, evaluation and reporting, plan management, financial management, and consumer support. 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 with the priorities of monitoring and data collection to improve functionality.

Fiscal Impact of the Exchange

Rhode Island's exchange development and implementation will have direct and indirect fiscal and economic impacts. For example, affordable health insurance coverage through the exchange could allow the state a decrease in uncompensated care costs among the currently uninsured using hospitals as the primary provider of health care. Similarly, Medicaid expansion facilitated through the exchange eligibility system could impact the state's cost sharing. The existence of the exchange could also enable the state to make a decision about moving certain populations from Medicaid or state-funded coverage to the exchange. Further, the positive externalities of expanded health care could promote gains

in workforce productivity, new opportunities for health care revenue and employment, and savings through lower uncompensated care payments.

According to the ACA, exchange construction will be federally funded. Grants secured by Rhode Island for early and comprehensive action in addressing the IT infrastructure necessary to accommodate the ACA represents an opportunity for the state to leverage federal resources and implement an effective exchange. While exchange construction is federally funded, Governor Chafee's executive order necessitates a long-term plan for self-sustaining exchange operations. Governor Chafee also required that current state entities must support the RIHBE by providing full-time equivalent personnel for administrative, technical, and other support. Creators of the exchange are currently planning four categories of financial management for the exchange: exchange accounting, premium processing, exchange sustainability, and risk adjustment/reinsurance.

Although there is no direct cost to the state to establish the exchange, risks to the budget relate to this long-term operation and sustainability. After initial construction, the state must plan for the costs associated with the long-term maintenance of the exchange. The exchange's viability is also contingent on a certain level of enrollment to achieve economies of scale: too few purchasers in the exchange may also adversely affect plan costs.

Even with federal subsidies, plans offered through the exchange may still prove unaffordable for some. To this end, the state may have to consider offering a Basic Health Plan outside of the exchange. Increased outreach and awareness related to the exchange and the ease of access may prompt a woodwork effect of enrollment among a larger proportion of currently Medicaid-eligible, but unenrolled individuals. Unlike the expansion population, currently eligible enrollees are not qualified for the enhanced FMAP rates for federal cost sharing and could increase the state's Medicaid costs.

Exchange Grants

For planning and implementation, the federal government has awarded three types of grants to states. In August 2011, 46 states received Early Planning Grants of about $1 million to enable exchange research and early planning. Four of the five New England states, including Rhode Island were awarded these grants. Seven states, also including Rhode Island were also awarded a total of about $117 million from 2011 Early Innovator grants by the U.S. Department of Health and Human Services. These cooperative agreements were awarded to help states design and implement exchange information technology.

In 2011 and 2012, the federal government awarded a total of $667 million in Establishment Grants to states that had received Early Planning grants. Level One Establishment Grants provided up to one year of funding, with possible one-time renewal, for states that demonstrated progress with Early Planning Grants. Level Two Establishment Grants provide funding through 2014 for states that demonstrated specific significant progress in establishing an exchange.

Table 6
Rhode Island Exchange Grant Amounts by Source ($ Millions)

Exchange Planning	Exchange Establishment	Early Innovator	Total Amount
$1.0	$63.8	N/A*	$64.8

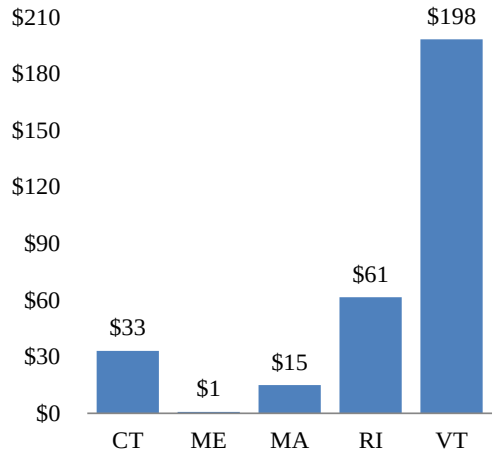
*The grant awarded to the University of Massachusetts Medical School is for a multi-state consortia, which includes Connecticut, Maine, Massachusetts, Rhode Island, and Vermont.

SOURCE: The Kaiser Family Foundation, Total Health Insurance Grants as of FY 2012

Rhode Island has been awarded a total of $63.8 million in Establishment grants, for a total of $64.8 million in federal exchange funding, as shown in Table 6. Exchange Establishment Grants consist of Level One and Level Two awards, providing Rhode Island with about $5.2 million and $58.5 million of federal funding, respectively. The Level Two grant, awarded in November 2011, will fund the development, design, and technology procurement of the exchange through December 2014. Rhode Island's total federal grant funding ranks the state the thirteenth highest nationally.

On a per capita basis, Rhode Island's federal grants of $61 per capita were the second highest nationally and in New England (behind Vermont), as shown in Chart 3. In general, the New England states received high levels of exchange funding. Vermont received $123.3 million, the sixth largest total of grants nationally. Connecticut received the seventh highest amount overall with $116.6 million in federal grants, and Massachusetts ranked eighth highest, with $98.8 million in federal grant support. New Hampshire is not eligible for grant funding as they have not passed legislation authorizing the creation of an exchange.

Chart 3
Grant Awards per Capita



Exchange collaboration among New England states has been the largest multi-state effort in the country. The five collaborating New England states have shared a $36 million federal Early Innovator grant, which was awarded to the University of Massachusetts Medical School in 2011 to fund technology research and development for exchanges.

In addition to federal grants, Rhode Island, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network (SHRAN). States can use SHRAN assistance for setting up exchanges, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms, and using data to drive decisions.[12]

[12] Other recipient states: Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon and Virginia.

Table 7
RIHBE Spending to Date

Federal Grants	Funds Received	Funds Spent	% of Total
Exchange Planning	$1,000,000	$979,981	98.0%
Establishment One	5,240,668	1,792,639	34.2%
Establishment Two	58,515,871	636,355	1.1%
Total	$64,756,539	$3,408,975	5.3%

SOURCE: RIPEC calculations based on state documents

Table 7 shows total spending toward the development of the RIHBE. To date, Rhode Island has spent $3.4 million (5.3 percent) of the $64.8 million the state has received in grants. The majority of this spending, nearly $3.0 million, went to contractor costs, while personnel costs account for $333,776.[13].

Since September 2010, three consulting firms have been awarded contracts to work on the RIHBE. As the exchange project director, Faulkner Consulting Group has been awarded contracts toward establishing the RIHBE. Contracts were also awarded to Wakely Consulting Group in Boston for health policy and exchange expertise, and Day Health Strategies in Somerville to provide consumer support expertise in the development of the RIHBE.

Exchange Cost Considerations

Exchange maintenance, a contact center, and other elements of exchange technology and customer service will demand resources beyond the initial investment for construction. Exchange creators are currently assessing self-sustaining methods of funding that do not rely on the state's general revenues. The RIHBE Commission will evaluate options, including passing the cost of the exchange to consumers, or making an indirect general assessment across the population that will access information and services through the exchange infrastructure by taxing insurers. Sharing resources with Medicaid could also help defray the cost. This partnership will allow Medicaid and exchange programs to share functions and capitalize on economies of scale. Shared functions may include joint procurement of contracts, purchases, processes, and technologies, as illustrated by the joint RFP for an eligibility system in May of 2012.

The RIHBE will also leverage opportunities with partner states in the New England Collaborative. As with the potential for Medicaid partnerships, RIHBE operators can share processes and technologies, particularly information technology, with other New England states. As is required in the ACA, shared information includes computer codes, as well as general information on progress and best practices. Rhode Island is also partnering outside New England to work closely with Maryland and Oregon on policy development for the exchange.

Expanding Coverage

As described previously, an estimated 70,000 Rhode Islanders could receive health coverage through the implementation of the ACA. New consumers are likely those who

[13] "State Spends $64M on Health Insurance Web Site", 27 November 2012. http://www.golocalprov.com/news/state-spends-64m-on-health-insurance-web-site/

cannot currently afford insurance. The subsidies provided in the form of tax credits, in combination with Medicaid expansion, are intended to promote affordability. The individual mandate is expected to drive remaining individuals to purchase coverage. Reducing the number of uninsured Rhode Islanders could improve health outcomes through access to primary and preventative care, and reduce emergency-related expenses.

Increased insurance coverage for the currently uninsured through the exchange could reduce state DSH payments. Nationally, the Urban Institute projects DSH to fall by about half through ACA measures to reduce the number of uninsured Americans. In FY 2012, Rhode Island spent $126.9 million in state and federal funds on DSH expenses. Projected FY 2013 and FY 2014 DSH spending for Rhode Island is estimated at $129.0 million and $135.3 million, respectively.

Expanding Medicaid could also mean an increase in state spending. New general revenue at the current FMAP would be necessary to fund the presently Medicaid eligible but unenrolled if they enroll into Medicaid. However, this increase could also mean an influx of federal reimbursement funds for the expanded Medicaid population. Medicaid Expansion populations are fully funded by the federal government through 2017, and remain eligible for an enhanced FMAP with a floor of 90 percent funding after 2020. Careful consideration of grant allocation for exchange development and federal funds that could accompany Medicaid expansion is necessary to capitalize on this opportunity and generate a high return from federal investment.

State Maintenance of Effort (MOE)

The ACA requires that states maintain their current eligibility standards for Medicaid and the Children's Health Insurance Program (CHIP). These MOE requirements apply to adults until the major components of health reform go into effect on January 1, 2014, and to children until September 30, 2019. During this period, states are prohibited from imposing enrollment barriers on those currently eligible (or those who may be eligible in the future) for Medicaid or CHIP. These requirements are designed to make sure that people do not lose coverage before the components of the ACA are fully enacted. However, as per the Supreme Court decision, states cannot be penalized for opting out of Medicaid expansion.

The impact of the Supreme Court decision on MOE requirements in Rhode Island is complicated by EOHHS' Medicaid 1115 Research and Demonstration Waiver agreement. In general, if states are experiencing or projecting budget deficits, they may apply for an MOE waiver in order to reduce eligibility requirements for optional populations. Rhode Island currently offers Medicaid coverage to several optional populations, which could be reduced with CMS approval by amending the Medicaid 1115 Research and Demonstration Waiver. The exchange gives the state the opportunity to consider moving optional populations, like parents up to 175 percent FPL, from state-funded coverage or Medicaid and into the exchange. The state could continue to support these individuals with wraparound coverage.

Constitutional Challenges to the RIHBE

Background

In late March 2012, the U.S. Supreme Court heard oral arguments in the *United States Department of Health and Human Services vs. Florida*. In this case, Florida challenged the constitutionality of several components of the ACA of 2010, including Medicaid expansion and the individual mandate. The individual mandate requires individuals to purchase some form of health insurance by January 1, 2014.

Plaintiffs from Florida argued that the ACA individual mandate is not a valid exercise of Congress' legislative power, including its power to regulate commerce and levy taxes. Counter-arguments came from the federal entities charged with implementing the ACA: the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. All arguments related to the constitutionality of the individual mandate centered around three constitutional provisions: the Commerce Clause, the Necessary and Proper Clause, and the Taxing Power. Opponents to the mandate argued that it is unconstitutional to require the purchase of a private good (in this case, health insurance) and to infringe on individual rights. Supporters argued that the mandate serves to regulate interstate commerce. They also contended that the mandate plays an important role in stabilizing insurance markets and bringing down premiums, two key goals of the ACA.

In June 2012, the Supreme Court upheld the individual mandate as a reasonable exercise of Congress' power to tax. It also upheld the constitutionality of Medicaid expansion, but ruled that states could not be penalized for opting out of this expansion. The Court voted 5 to 4 to uphold the Act, with Chief Justice Roberts joining the majority opinion.

Impact of the Supreme Court Decision on Exchanges

The Supreme Court decision to uphold the constitutionality of certain provisions of the ACA will allow states to continue to move forward with implementation of the law. The timing of the decision was critical for Rhode Island, because the state had already invested significantly and benefited from federal funding to develop and implement a statewide exchange, despite the legal uncertainty surrounding the case. Ultimately, the Supreme Court decisions have allowed the state to continue this work unabated.

The impact of the individual mandate on the expected outcomes of the ACA immediately relates to three major factors critical to the success of the RIHBE: insurance premiums, the number of uninsured individuals, and government spending. The Urban Institute found that without the mandate (though with other components of the law intact) premiums for insurance offered through exchanges would likely increase by 10 to 20 percent compared to projected levels with the mandate, and between 40 and 42 million

Americans would remain uninsured.[14] The Rand Corporation determined that under the same circumstances, premiums for individuals purchasing insurance through an exchange would increase by 2.4 percent, but approximately 12.5 million Americans would be uninsured.[15]

Recent research has also projected that government spending per enrollee would increase if the individual mandate was struck down. The Urban Institute contends that much of this spending would be in the form of uncompensated care for the uninsured. According to the Rand Corporation, government spending could increase by 50 percent, as compared to projected spending with the mandate. [16]

Comments

The ACA represents a major shift in the way in which individuals will be able to access health care in the United States. The intent of the law is to expand coverage and access to affordable and quality health care. Beyond the extension of Medicaid eligibility to childless individuals up to 138 percent of the FPL, the creation of health care exchanges will facilitate coverage to a large group of people for whom coverage may have been unaffordable previously. At the same time, how states implement these exchanges will go a long way towards determining just how affordable and accessible health insurance will be under the ACA.

There are a number of ACA components that may have broad positive effects, from a healthier population through increased access to health care to positive economic returns for the state. At the same time, decisions regarding exchange eligibility, careful implementation, and long-term sustainability will determine how effective the HBE is for the state. Three specific areas of focus for the state are the interaction between the exchange and Medicaid, the design of the exchange itself, and the ability for the exchange to be self-supporting in the future. All three of these considerations will impact the makeup of the population using the exchange, and the number and type of consumers in the exchange will drive the affordability of plans and cost of operations.

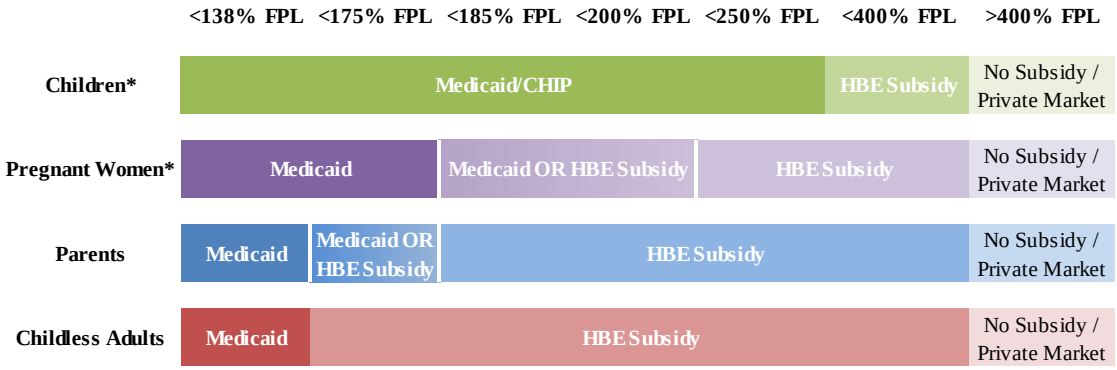
The Interaction between the Exchange and Medicaid

As the state moves forward with implementation of the ACA, it must be mindful of the interaction between the exchange and Medicaid, as they are fundamentally inextricable. The exchange and Medicaid should be designed to offer a continuum of coverage as an integrated system for Rhode Islanders. The design and structure of both the state's Medicaid offerings (e.g. the income cut-off for eligible parents) and the exchange (e.g. the type and cost of coverage) will impact the ultimate viability of both. As such, both the Executive Office of Health and Human Services (EOHHS) and the exchange must work in concert – including sharing information and planning.

[14] Linda J. Bloomberg, Matthew Buettgens, Judy Feder. *The individual mandate in perspective.* Urban Institute. 2012 and Matthew Buettgens and Caitlin Carroll. *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care: Timely Analysis of Immediate Health Policy Issues.* Urban Institute, January 2012.
[15] Rand.org. http://www.rand.org/pubs/research_briefs/RB9646/index1.html. Retrieved May 2012.
[16] Rand.org. http://www.rand.org/pubs/research_briefs/RB9646/index1.html. Retrieved May 2012.

Eligibility decisions made by Medicaid will impact the demographic and size of the population purchasing within the exchange. For exchanges to operate efficiently, stabilize premium costs, and be self-sufficient, there must be enough individuals purchasing through exchanges. Higher income limits for the non-expansion Medicaid population will reduce the number of individuals eligible to purchase through the HBE, thereby potentially affecting the sustainability of the exchange. At the same time, if exchange offerings are not economically viable for these populations, individuals may opt for the penalty and forego coverage, potentially increasing DSH-related expenditures and, thus, costs to the state.

Chart 4
Medicaid/Exchange Population Distribution and State Decision Points



* ACA Maintenance of Effort requires RI cover children up to 250% FPL and pregnant women up to 185% FPL through Sept. 30, 2019
SOURCE: State Medicaid documents, Affordable Care Act

To address this issue, the ACA allows for implementation of a Basic Health Program (BHP), a public health insurance plan available to individuals whose incomes are above the cutoff for Medicaid, but below 200 percent of the FPL. To support this plan, states may access a portion of federal funds that would otherwise go to subsidizing the purchase of insurance through the exchange for this population. While this program could ensure greater levels of coverage and mitigate the risk to the state through uninsured emergent care use, there is concern that a BHP would undermine the intent – and viability – of the exchange while potentially increasing costs to the state in the long run. Given the substantial risks to the state and the exchange, it would be prudent for the state to take a wait and see approach regarding implementation of a BHP until more is known about the interaction between Medicaid and the exchange, and whether coverage continues to be unaffordable for a large number of families or individuals.

Exchange Design

Rhode Island is well-positioned with regard to exchange development and implementation. The state has moved quickly, and has been successful in securing grant funding for the development and implementation of the exchange. As such, other states have considered Rhode Island a model for early-acting, collaborative, integrative

exchange efforts. With this funding and early action, Rhode Island's HBE developers can capitalize on information sharing and the opportunity to leverage pooled resources with other programs and other states. Additionally, the state should consider "lessons learned" from Massachusetts, a partner recipient of the Early Innovator Grant, with regard to their experiences with the design and implementation of the Commonwealth Connector.

The more user-friendly the design, the more likely individuals will be to use the exchange to research and purchase health insurance. Concerns in this area are two-fold. Specifically, the system needs to be designed to be easily navigable for individuals with low levels of health and computer literacy. Successfully navigating these two challenges will help the HBE meet its dual goals of increasing affordable coverage and improving health outcomes.

Table 8
Guiding Principles for Exchange Design

Accessible	Individuals must be able to easily access the portal and information contained therein
Navigable	The site must be easy to navigate, with relevant information and options clearly organized, and an intuitive/adaptive interface
Comprehensible	Information must be clear, free of jargon, well-defined, and presented up front
Manageable	Limited, but sufficient, options to meet consumer needs without being overwhelming
Current	Responsive to systems change as needed, providing the most up-to-date information, plans and requirements to consumers

The purchase of health insurance is an area in which many consumers may have little to no experience. Lack of prior knowledge or an overwhelming process could discourage consumers from entering the exchange to purchase coverage. Plan transparency, clear explanations of plans and benefits, and understandable definitions of terms are crucial for consumers to understand their options and make an informed decision at the point of purchase.

One of the roles of the HBE should be to provide basic health insurance education, both to ensure consumers see the value of health insurance, as well as to empower the consumer to make informed decisions regarding coverage options. The number of options available to the consumer should also be taken into account. Too many options may, ultimately, be overwhelming to consumers, particularly to populations who have little or no experience with the health insurance market.

Particular attention should be paid to the varying levels of computer literacy that exist across the different demographic groups eligible to purchase through the exchange. While the demands of the system are great, the user-interface should be as simple and straight-forward to navigate as possible, and individuals should be able to easily find answers to their questions or get assistance from knowledgeable and helpful support staff. The consumer experience would be complimented by an accessible contact center to support the process and respond to follow-up questions. The state may wish to partner

with organizations such as the Broadband Digital Literacy Program and local libraries to host training sessions to enable these organizations to serve as intermediaries. Pursuing outreach strategies similar to those in the Children's Health Insurance Program (CHIP) may also help increase access to the portal.

Long-term Funding for the Exchange

Both the ACA and the Governor's executive order establishing the exchange require it to be self-sustaining. How the state decides to support the exchange, however, will have an impact on the exchange, particularly its long-term viability. While the cost of HBE development is fully funded by exchange grants, continued infrastructure maintenance, customer service, and staffing needs must be met moving forward. Although the state should be able to reasonably estimate the operating and capital costs for the exchange after it is established, the uncertainty surrounding the number and type of exchange consumers remains an unknown. As such, revenue generated through the HBE, at least in the first few years, will remain a moving target. Further, fixed expenses may create a relatively high cost per participant for the exchange in comparison to other states.

The HBE has several options for generating revenue to support its operations:

- A premium surcharge levied on the consumer that is set at a percent of premium;
- A "user-fee" that is a flat rate charged to exchange participants; or
- An assessment on participant insurers on gross or net premiums or on profits.

While it does not appear that any state has declared how they will finance the exchange, it appears that the federal exchange will be funded through a premium surcharge, capped at 3.5 percent of monthly premiums and that many states will follow suit. The primary benefit of this financing mechanism is transparency. Consumers can easily identify the cost of the plan, and the additional cost to support the HBE, as long as the surcharge is shown separately. Similarly, a user fee would be a highly transparent funding mechanism. In contrast, an assessment on participant insurers, which will likely be transferred to the consumer in the form of higher premium costs, is substantially less transparent. Additionally, any assessment on insurers may put them at a competitive disadvantage and could prove a barrier to entry into the Rhode Island market, potentially impacting the affordability aspect of the exchange.

The size and structure of either a premium surcharge or user fee will impact affordability and, potentially, the number of users of the exchange. A flat user fee, while probably the most transparent, is also the most regressive and may provide a disincentive to those in the lower income brackets to purchase insurance. However, a user fee that is scaled to income may mitigate this issue. Alternatively, a premium surcharge may allow for the same type of scaling as it would be tied to the cost of a plan, but is more closely tied to decisions made by the consumer.

Setting the price point for a user fee or surcharge is dependent on two things: the operational and capital costs associated with the exchange, and the number and type of enrollees. In order for the exchange to be self-supporting, revenue derived from either

option must be greater than or equal to operating costs. Because of the uncertainty of the number of enrollees, thus, the amount of revenue generated, it is imperative the HBE operates as efficiently as possible. By keeping costs low, the exchange is more likely to be able to be sustainable and the lower the assessed surcharge will need to be.

Exchange Funding - User Fee

$$\text{Exchange Costs} = \left(\text{Fixed Costs} + \text{Variable Costs}\right) = \left(\text{\# of Exchange Users} * \text{Fee}\right)$$

Exchange Funding - Premium Surcharge

$$\text{Exchange Costs} = \left(\text{Fixed Costs} + \text{Variable Costs}\right) = \left\{\text{\# of Exchange Users} * \left[\text{Fee} * \text{Premium}\right]\right\}$$

Another consideration is how to ensure a sufficient population of users for the HBE. Specifically, the larger the number of enrollees, the lower price point as the cost is distributed over a larger group and the more fiscal flexibility the exchange will have in the long run. How the state sets income thresholds for Medicaid, and whether the state adopts a BHP will have an effect on the exchange population. Likewise, while marketing can be an expensive proposition, the state and exchange should work to enhance awareness by partnering with community groups, particularly those that engage with the state's diverse cultural, linguistic, and ethnic populations. As noted earlier, these efforts should also focus on how best to reach populations with low levels of health and computer literacy.

The final issue for consideration is that of accountability and oversight. Rhode Island has the ability to design and construct a user-friendly portal, well-integrated with other state programs. This portal will not only facilitate expanded access to health insurance coverage, but it has the potential to generate additional positive returns to the state such as expansion of the health care industry and additional federal funds flowing through the state, and higher worker productivity associated with better health status. However, the success or failure of the exchange is dependent on a number of elements, such as design, take-up rates, access, marketing, and operational costs. In order to ensure the HBE reaches its goals, high levels of accountability, with clear delineation of responsibility, and adequate oversight are imperative. Rhode Island has a head start and has made substantial progress on the exchange so far, and with careful execution can continue to be a vanguard in this area.