

ACA Implementation—Monitoring and Tracking

Rhode Island

Site Visit Report

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses. The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION

Rhode Island has been a long-standing leader in improving access to health care and has continued to play this role following passage of the Patient Protection and Affordable Care Act of 2010 (ACA). As a result of the ACA, the state has committed to making health reform work for Rhode Islanders and is a nationally recognized leader in efforts to implement an operational health insurance exchange. The state has completed many essential steps toward establishing an exchange and, in November 2011, became the first state in the nation to receive a level two exchange establishment award from the federal government following its successful bids for a planning grant and a level one establishment award.

Though the state has not passed new legislation implementing the ACA's private health insurance market reforms, many of these protections were in place, by practice or law, before passage of the ACA, and the state is actively studying ACA-related changes to its private health insurance market. Rhode Island is also well placed to implement the ACA reforms regarding Medicaid, in no small part because the state expanded its Medicaid program as long ago as the 1990s to provide coverage for children and parents up to 250 and 175 percent of the federal poverty level, respectively. The passage of the ACA—and the opportunity for federal funding necessary to implement broad reforms—has allowed Rhode Island

to view the federal law as an opportunity to build upon the foundation for reform it has been working toward for nearly 15 years.

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Much of Rhode Island's success in implementing the ACA is the result of the efforts by state officials to continue making health care reform a high priority in the state. In spring 2010, the lieutenant governor established a volunteer, 150-member Healthy R.I. Task Force, representing a broad spectrum of stakeholders, to monitor opportunities for federal funding, begin to identify the ways that federal health reform would affect the state, and think through the design and operation of a health insurance exchange. Through this collaborative process, Rhode Island has applied for and received numerous federal grants, developed the foundation of its exchange, and established working groups to oversee planning and implementation.

Following the election of Governor Lincoln D. Chafee in 2010, Rhode Island became much more active in formalizing its efforts to promote meaningful health reform. A mere two weeks after his first day in office, the governor issued an executive order to establish the Rhode Island Healthcare Reform Commission (Commission) and appointed Lieutenant Governor Elizabeth Roberts as its chair. Under the executive order, the Commission is directed to “address specific issues in healthcare reform, including but not limited to implementation of national reforms under the federal Affordable Care Act.”¹ To identify and address these issues, the Commission has seven workgroups: exchange development, payment and delivery reforms, data and evaluation, workforce needs, policy and legal issues, communication and outreach and long-term care. Within the Commission, there is an executive committee with the following permanent members: the lieutenant governor, the director of the Department of Administration, the health insurance commissioner, the secretary of the Office of Health and Human Services and the director of the governor’s Policy Office. This executive committee provides recommendations to the governor and the legislature and can accept funds, hold hearings and contract with experts and consultants as necessary.

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Despite the efforts of the Healthy R.I. Task Force and the Commission, the Rhode Island legislature failed to pass legislation in 2011 to establish an exchange. Though the bill had broad support and was expected to pass both chambers, it was ultimately derailed by a contentious

amendment restricting the purchase of abortion coverage with private funds. Ultimately, the governor signed an executive order to establish the Rhode Island Health Benefits Exchange as a new division within the state’s Executive Department, which was an option that policymakers had discussed even before the introduction of proposed exchange legislation.

The executive order established an exchange that mimicked the design included in the proposed legislation. It was challenged in December 2011 by state lawmakers and a pro-life advocacy group claiming that the governor overstepped his legal authority and violated the Rhode Island Constitution by taking unilateral action to establish an exchange. Despite this challenge, Rhode Island is likely to continue its efforts to implement an exchange using the three-year level two establishment award of \$58,515,871 it received in November 2011 and building upon its partnership with the New England States Collaborative for Insurance Exchange Systems (NESCIES), a federally funded project focused on developing exchange information technology (IT) components that can be leveraged by multiple states.

Rhode Island has a relatively high rate of employer-sponsored insurance (60 percent) and a large share of its nonelderly population on Medicaid (20 percent).² As a result, the state has an uninsured rate of 13 percent. Using the Urban Institute’s microsimulation model, we estimate that the number of uninsured would fall by 57,000 to an estimated 7 percent following the implementation of health reform. The number of Medicaid enrollees would increase by 38,000, and the number of people enrolled in coverage through the exchange would be 92,000: 53,000 in the nongroup exchange and 39,000 in the Small Business Health Options Program (SHOP) exchange. The rate of employer-sponsored insurance is expected to remain about the same as without the reform.

EXCHANGE IMPLEMENTATION AND PLAN PARTICIPATION

As noted above, Rhode Island stakeholders have been working toward establishing an exchange as defined under the ACA since spring 2010. These early efforts proved critical one year later when the Rhode Island legislature failed to pass legislation, S.B. 87, that would

have established a quasi-public state exchange.³ The legislation—drafted in consultation with governmental agencies and elected leaders—had broad support before being derailed by an amendment that would have been more stringent than the federal law in restricting the

purchase of abortion coverage in the exchange.⁴ Though the legislation did not pass, it would have established an exchange with an 11-member board, a governor-appointed executive director, strict conflict of interest provisions, and functions and operations limited to the minimum federal requirements for establishing an exchange.⁵

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Even before such legislation was introduced, state policymakers began to analyze the possibility of using an executive order to establish the exchange within an existing state agency. In July 2011, the Executive Committee of the Rhode Island Healthcare Reform Commission recommended to the newly elected governor that he establish an exchange through an executive order.⁶ Executive Order 11-09 was signed on September 19, 2011, and established the Rhode Island Health Benefits Exchange as a new division within the state's Executive Department.⁷ The executive order derives its legal authority from a state statute passed in 1974 establishing a health resources development fund.⁸ The fund can receive monies from insurers and other sources, including the federal government, to reduce the ranks of the uninsured and address health cost, quality and access.⁹ While an exchange executive director has yet to be appointed, the governor used this authority to appoint the exchange board, which held its first meeting on October 6, 2011.

Executive Order 11-09 largely adopted the exchange model included in the proposed legislation to give the state the flexibility to place the exchange in a quasi-public structure with the same staff and operations if the legislature later approved of such a model. Despite many similarities, there are a few notable differences between the legislation and the executive order. First, the exchange has much less administrative flexibility as a division within the Executive Department than it would as a public corporation. For example, its abilities to hire staff quickly, segregate revenues and expenses from the state budget, and procure components of the IT system are more constrained. The executive order attempted to mitigate this difficulty by placing the director of the Department of Administration on the exchange board. Second, although informants emphasized that the recommendations of the exchange board will be valued, the executive order limits

the board to playing an advisory role to the governor.¹⁰ Third, the scope of the exchange's function is broader under the executive order—where it is directed “at a minimum” to carry out the federal requirements—than it was in the failed legislation, which limited exchange action to only what was needed to comply with minimum federal requirements.¹¹ Fourth, unlike the legislation, the executive order repeatedly emphasizes the need for the exchange to play a role in broader health reforms by, for example, “promot[ing] cost containment and quality improvement.”¹²

Though much progress has been made in operationalizing the exchange under Executive Order 11-09, the legislature may renew its efforts to pass exchange legislation in 2012. In addition, on December 1, 2011, twenty-eight state lawmakers and Rhode Island Right to Life, a pro-life advocacy group, filed a lawsuit against the governor challenging his legal authority to establish an exchange under executive order 11-09.¹³ The complaint does not mention abortion and was filed two days after Rhode Island was awarded its exchange level two establishment award.¹⁴ Government informants appeared confident that the executive order would be upheld if challenged.

Progress in Operationalizing the Exchange

Rhode Island has made significant progress in planning and implementing its exchange. Recognizing the need for federal assistance, Rhode Island pursued all available federal funds and received three sources of federal exchange funding: a planning grant (\$1,000,000), a level one establishment award (\$5,240,668) and a three-year level two establishment award (\$58,515,871). In addition, Rhode Island is working in partnership with the New England States Collaborative Insurance Exchange Systems (NESCIES), a project that received \$35.5 million in federal funds to develop exchange IT components that can be leveraged by multiple states. Federal assistance has proved vital to Rhode Island's exchange efforts and will likely continue to be important: one informant suggested that even a small state contribution requirement would have effectively stopped Rhode Island from moving forward with exchange plans, while another noted that the state had considered an exchange a few years earlier but ultimately rejected the idea because of a lack of funding. This federal funding has helped Rhode

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Island make tremendous progress toward exchange planning and establishment. Under its planning grant and level one establishment award, the state secured an executive order to establish and operate an exchange; developed a governance model with standards for public accountability and transparency; and established an advisory exchange board, stakeholder advisory committees and other consultative processes.¹⁵ The state also developed a purchasing strategy and began assessing potential vendors for critical functions such as data reporting and consumer support.¹⁶ Finally, to inform its exchange efforts, Rhode Island commissioned studies that include market analysis reflecting the state's small size and scale, a study of exchange financing models, a report on interagency program integration needs, and an analysis of existing IT gaps, among others.

Rhode Island is the first state in the nation to receive a level two establishment award. In its grant proposal, the state provided a detailed work plan to operationalize an exchange by 2013 using three strategic principles: a joint implementation effort between the exchange and the state Medicaid agency, outsourced implementation using service providers for business and IT needs, and a focus on leveraging the state's involvement in NESCIES and other Early Innovator grantees.¹⁷ These principles informed Rhode Island's work plan, which identifies seven major project areas: operations/IT infrastructure, consumer support, reporting and evaluation, governance and staffing, health plan certification and qualification, financial sustainability and oversight, and financial integrity.¹⁸ Despite the detailed work plan included in the level two establishment grant proposal, government informants recognized the need for continued flexibility in the planning and establishment process and suggested they were willing to adjust their formal planning process as their vision for the exchange becomes more well-defined. This flexibility may prove critical because Rhode Island received about \$16 million less than its \$74.5 million request, and it is unclear how this shortfall will affect the state's efforts moving forward.¹⁹

One likely reason for Rhode Island's success thus far is that exchange supporters have adopted a broad vision of health reform to frame their efforts. The need for meaningful health system reform was reflected in the executive order and the Commission's efforts, which aim to address a range of issues beyond access to coverage.²⁰ Through this broad health reform lens, informants in Rhode Island largely discuss the policy issues in terms of what is good for the state and how federal reforms, including the establishment of

an exchange, can be used to leverage broader state health reform goals. Though this view is popular, not all stakeholders agree, and some have raised concerns that goals such as driving policy reform and regulating the market are overly ambitious and that exchange planning should focus more narrowly on creating a new marketplace that is attractive to consumers.

The interagency exchange workgroup—co-chaired by the health insurance commissioner, the Medicaid director, and the lieutenant governor's chief of staff—has taken an active role in much of the exchange planning and implementation to date.

Exchange efforts in Rhode Island also appear to have benefited from strong leadership and interagency collaboration among dedicated individuals. The interagency exchange workgroup—co-chaired by the health insurance commissioner, the Medicaid director and the lieutenant governor's chief of staff—has taken an active role in much of the exchange planning and implementation to date. Two of these leaders, the Medicaid director and health insurance commissioner, recognized early in 2010 that health reform would affect both agencies and worked together to prepare Rhode Island's exchange planning grant. Although the Office of the Health Insurance Commissioner (OHIC) has been the formal applicant for federal exchange grants, the workgroup agreed to jointly administer such grants and formalized their collaboration in two memorandums of understanding.²¹ The partnership quickly grew to include representatives from the Executive Office of Health and Human Services, OHIC, the Department of Health and the lieutenant governor's office and also includes support from an exchange project director, a small staff and a number of consultants. The workgroup meets at least weekly to discuss and guide ongoing planning and implementation efforts. Indeed, informants credited much of the state's success to the leadership's dedication, commitment and the fact that the "people at the top had the inclination to cooperate."

In addition to their leadership on the interagency exchange workgroup, these individuals and the agencies they represent are key players in the planning and establishment process. For example, these agencies play overlapping roles in exchange planning and

implementation through their membership on the interagency exchange workgroup, as ex-officio voting members of the exchange board, and as members of the executive committee of the healthcare reform commission, which makes formal recommendations to the governor. The ability of agency leaders to be involved at every level of decision-making could prove critical because many members of the exchange board are not health insurance experts and have varying degrees of health policy experience. Exchange board participation is notably limited because executive order 11-09 contains strict conflict of interest provisions that bar the participation of individuals that are employed by or a consultant to insurance companies, insurance trade associations, agents or brokers, providers or health care facilities.²² Though one government informant suggested that this was a trade-off to make the board representative of the broader community, an industry informant described it as nonsensical to exclude individuals with the most insurance-related expertise from participating on the exchange board.

Though the interagency exchange workgroup is heavily involved in planning and implementing the exchange, another likely reason for Rhode Island's success is that input is received from a broad spectrum of stakeholders. The interagency exchange workgroup works closely with the exchange working group, which was established by the Healthcare Reform Commission, and has an open membership policy with active participants that include business representatives, consumer advocates, providers, issuers and brokers. Under the executive order, the exchange board is also required to consult with a newly formed expert advisory committee comprising representatives of insurers, agents and brokers, providers and other health industry experts. Informants suggest that this process has allowed stakeholders to exchange ideas in an open forum that has provided a basis for mutual understanding, even among individuals that hold vastly differing views about exchange implementation.

Major Policy Decisions

Although Rhode Island has progressed in operationalizing its exchange, the formal Rhode Island Health Benefits Exchange was established only recently when Executive Order 11-09 was signed on September 19, 2011. While it is remarkable that Rhode Island has made so much progress and received its level two establishment award fewer than three months after the executive order was signed, many major policy decisions have not been

formalized because the formal decision-making process, including a sitting exchange board, is relatively new.

That being said, some policy decisions appear inevitable even if not officially approved by the governor. First, there appears to be broad consensus that the exchange should serve more than simply the uninsured. One government informant indicated that the ideal exchange model would be a public utility serving all residents, not just the 70,000 new individuals purchasing health insurance. To do so, stakeholders have adopted a "single project vision" that integrates the exchange with Medicaid and other assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) and Rhode Island Works, the state TANF program.²³ As discussed further below, stakeholders did not always conceive of the exchange this way and only recently embraced a vision of a fully integrated exchange model.²⁴

Second, stakeholders appear to support at least some type of active purchasing role. The language of the executive order requires as much by instructing the exchange to "seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."²⁵ In addition, stakeholders issued a brief in August 2011 on this issue, noting that active purchasing is not a new concept in Rhode Island because the state plays such a role in procuring managed care contracts under RlTe Care.²⁶ Though it identified arguments against an active purchasing role, the brief ultimately recommended that the exchange "have authority to aggregate the purchasing power of individuals and small business to leverage lower premiums ... [and] higher quality products and payment reforms."²⁷ In addition, a majority of stakeholders supported an aggressive purchasing model akin to RlTe Care and recommended that the exchange align its purchasing strategies with public programs and the state employee health plan to increase the exchange's purchasing power.²⁸ Despite these recommendations, some industry informants expressed concerns about the language of the executive order and questioned why the exchange needed to play an active purchasing role, especially in light of the state's stringent rate review process. Most informants, however, agreed that there is an expectation that the exchange will play such a role.

Although Rhode Island has made some unofficial decisions, most informants acknowledged that many critical decisions have yet to be made. Issues that Rhode Island has discussed but has not come to a decision

on include, among others, how to design the SHOP exchange,²⁹ whether plans should be standardized,³⁰ a financing system for the exchange,³¹ and whether to adopt the Basic Health Plan (BHP).³² Repeated considerations in these policy discussions have been how to ensure the continuity of coverage for consumers, the scale of the exchange, the financial stability of the exchange and the financial risk to the state. Government informants also noted the need for more formal federal guidance to allow the state to move forward with its decisions, particularly in the context of essential health benefits (EHBs) and the BHP, where the state's decision to move forward may hinge on whether Rhode Island has the flexibility to extend a premium assistance program, modeled after its RItte Share program, to the BHP.³³

Sources of Controversy

Although it is difficult to anticipate which policy decisions will cause the most controversy in Rhode Island, particularly difficult issues may be the coverage of state-mandated benefits, whether to adopt the BHP and whether to standardize benefits in the exchange.

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Perhaps Rhode Island's most controversial decision—according to one informant, “the toughest fight in health reform for our state”—will be over the state's 42 mandated benefits. There is particular concern because state-mandated benefits that exceed the benefits required by the federal government must be paid for by the state, and the state may not be able to financially cover all the benefits. While government informants were anticipating controversy over how to address continued coverage of the state's mandates, the state could sidestep some of that controversy because of recent guidance issued by HHS. On December 16, 2011, HHS released a bulletin suggesting that, instead of one national standard for EHBs, states may choose among four benchmark options: (1) the largest small-employer plan in the state, (2) any of the three largest state employee health benefit plans, (3) any of the largest three national Federal Employee Health Benefits Plan options, or (4) the largest commercial health maintenance organization operating in the state. If Rhode Island

officials choose a benchmark plan that already includes existing state benefit mandates, they will be included as part of the minimum EHB and the state, at least in the near term, will not need to account for or pay for them as additional benefits.

Another controversial issue is whether Rhode Island will adopt the BHP. Though government informants were generally in favor of such a plan, support is conditioned on the plan's financial feasibility. Advocacy on the issue has already started, and the exchange board is discussing a BHP option while trying to gauge state financial risk and affordability.³⁴

Finally, benefit standardization is likely to be controversial; the topic was actively debated among stakeholders before agreement was reached on a recommendation that the exchange “have authority to standardize products to provide manageable—but meaningful—choices.”³⁵ Stakeholder comments ranged from noting that too many choices will be confusing for consumers to arguing that Rhode Island already has limited plan options so standardization should be limited.³⁶

One minor point of controversy stems from the strict conflict of interest provisions that excluded issuers, brokers and providers from the exchange board despite lobbying for representation. Informants suggest that, of the three interest groups, brokers were most aggressive in lobbying for board representation, possibly because the role of brokers in 2014 has not yet been determined. Despite this uncertainty, informants agreed that brokers have been and will continue to be involved in the exchange process and commercial markets in Rhode Island.

Insurer Participation and Expected Enrollment in Exchange Plans

Although Rhode Island is actively discussing how to attract plans into the exchange, this issue does not seem to be urgent among informants. Rhode Island has a highly concentrated market with only three commercial carriers: Blue Cross & Blue Shield of Rhode Island (BCBSRI), United Healthcare of New England (United) and Tufts Health Plan (Tufts).³⁷ Only BCBSRI offers coverage in the individual market, and all three issuers offer coverage in the small-group market. It is expected that all three issuers will participate in the SHOP exchange in 2014 and that United and Tufts may also enter the individual exchange market in 2014 because, as one informant put it, this would be too large a market for them to leave to BCBSRI alone.

EXCHANGE ENROLLMENT AND SUBSIDY DETERMINATION

Though much work remains to be done, Rhode Island has made substantial progress in developing a process for eligibility and subsidy determination. The interagency exchange workgroup is leading this effort and—having completed the exchange’s business process planning—is beginning to focus on developing technical standards to understand how the process will occur.

Rhode Island’s vision for the exchange is an “integrated, seamless, end-to-end” portal where consumers can access Medicaid, exchange plans and other human services programs online, through a call center, or in person. The state plans to implement such a vision in phases. Initially, the exchange will have the ability to enroll individuals that are income-eligible for Medicaid or the exchange. In its second phase, the exchange will have the functionality to determine eligibility for “legacy populations”—the elderly and disabled whose eligibility is based on current income definitions.³⁸ Finally, the exchange will be able to incorporate eligibility and enrollment for other human services programs such as SNAP and Rhode Island Works.³⁹

The “single project vision” is a departure from the state’s original plan and highlights a willingness of the interagency exchange workgroup to be flexible and adopt the proposals designed to best serve the state even if doing so means changing course. A number of factors appear to have led Rhode Island to reject its original idea that Medicaid and the exchange would be integrated solely through a business arrangement where the two programs would share a platform and portal services. These factors included a technology gap analysis that found that the current Medicaid eligibility system would be inadequate for 2014; the realization that Medicaid and the exchange would perform many similar functions, such as eligibility and appeals processing; a study analyzing expected exchange users; and the availability of favorable federal financing and encouragement by federal regulators to support this integrated approach. When asked what caused the state to shift toward the single project vision, one government informant pointed to Rhode Island’s recent request-for-information process where state officials met with 14 vendors over two days to review existing technology for eligibility systems and concluded that an integrated program would be the best approach.

Rhode Island has also identified specific priorities to develop its eligibility and subsidy determination process. One priority is the development of a rules engine that allows the exchange to collect and analyze information to assess continuing eligibility and changes in individual circumstances. Critical to Rhode Island’s needs, such a program must be nimble enough that end users, like state employees, can easily change the parameters without being forced to make fundamental programming changes at each turn.⁴⁰ Another priority is to procure a system that allows contact with federal agencies to use their data in making eligibility and subsidy determinations, which government informants indicated would likely be developed in partnership through the NESCIES.

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Program Integration

Rhode Island has been recognized as an innovator in exploring integration between the exchange, Medicaid, and other human services programs. Its efforts have been spearheaded by the interagency exchange workgroup, which established three guiding principles for developing a workable exchange: collaboration, integration and coordination, and regional solutions where appropriate. Rhode Island also used its level one establishment award to analyze what eligibility tools would look like if built to meet the needs of both Medicaid and the exchange, and one informant suggested that the federal exchange funding is viewed as an opportunity to substantially upgrade the state’s “primitive” eligibility systems. As discussed below, much of the state’s technological needs are driven by the vision of an “integrated, seamless, end-to-end” exchange.

Rhode Island’s success in program integration thus far may be attributed to its interagency collaborations. First, as noted above, the Medicaid director and health insurance commissioner began working together in 2010 to draft Rhode Island’s exchange planning grant

and have continued to work in conjunction with other members of the interagency exchange work group. The state's continued progress in program integration likely stems from this experienced leadership, effective interagency collaboration, and a shared commitment to operationalizing the exchange in a way that serves multiple agencies.

Developing the IT System

Rhode Island is making considerable progress toward developing an IT system—and business processes to be served by the IT system—that will play a major role in getting individuals enrolled for coverage. The interagency exchange workgroup, heavily supported by a number of outside consultants, has taken the lead on efforts to develop the IT system. As discussed above, Rhode Island's goal is to implement a "single project vision" that will provide one-stop shopping online, by phone or in person for both health programs and non-health human services programs. Under this vision, an eligibility system—supported by a single eligibility rules engine—would simultaneously determine eligibility for Medicaid, exchange plans and subsidies, and other programs. The system would also handle plan selection, enrollment and disenrollment, payment election, premium billing and collection, eligibility and benefit appeals processing, legal notifications and outreach and support communications. The new IT system will be funded by exchange implementation award funds and Medicaid funds with costs allocated between the two based on the number of people expected to be served by each program.

Implementing a sound IT system is a high priority to Rhode Island stakeholders, and the level two establishment grant proposal identified technology as one of the seven major projects for operationalizing Rhode Island's exchange by 2014. Rhode Island also indicated its decision to procure a health insurance exchange platform⁴¹ and identified about 30 components needed to implement the exchange. In addition, because of state IT staffing constraints, informants indicated that software functionality and hosting will likely be outsourced to a vendor. To continue its progress, a newly formed exchange operations workgroup—comprising IT experts from the government, Medicaid vendors and exchange consultants—is organizing a weekly planning summit to translate the exchange's design into a technical process. Additional next steps include establishing small interagency groups to further operationalize the exchange and applying business requirements to upcoming technical procurements.⁴²

As a state working in partnership with the NESCIES project, Rhode Island has looked to the Massachusetts-led collaboration with a particular interest in designing common technical components such as web-based enrollment, secure data transfer and real-time access to federal data.⁴³ Although Rhode Island is engaged in the collaboration and is part of the design team, informants expressed hesitation in the state's willingness to adopt the resulting technology if it fails to meet the state's needs. One informant noted that it has not yet determined whether the modules being developed through the NESCIES effort will "bear fruit" for Rhode Island, and a major issue will be to determine how much of the NESCIES system will be useful and what additional capabilities will need to be established. The state may decide to choose to work with its own vendor or, though more unlikely because of timing constraints, rely on the efforts in other Early Innovator states.

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Interagency working groups are currently developing the state's joint eligibility and technology request for proposals, which is expected to be issued in the first quarter of 2012 and will ask for technical specifications for the exchange platform and enrollment process.

Maximizing Enrollment in Medicaid and Exchange Plans

Rhode Island views consumer outreach and education as a critical component of a successful exchange. However, there is a "lack of capacity" to manage consumer inquiries and complaints because of limited staffing resources in both the Department of Business Regulation (DBR) and OHIC, as indicated in Rhode Island's Consumer Assistance Program grant.⁴⁴ Because of insufficient staffing, neither agency conducts comprehensive consumer outreach or education on health insurance nor aggressively publicizes its consumer assistance capabilities. Indeed, even though Rhode Island received a federal Consumer Assistance Program grant of \$149,880 with the intent of hiring additional staff, increasing communication between various agencies and programs,

expanding current department consumer inquiry and complaint capabilities and providing new departmental assistance with insurance enrollment and appeals, one government informant indicated that the DBR has yet to decide how to use this funding and that very little is being done to inform consumers of their rights. The same informant, however, suggested that consumer outreach through the exchange will be much stronger because the state can leverage its outreach capacities under Rlte Care to promote the new options that will be available in the exchange. In addition, Rhode Island's level two establishment grant proposal included a funding request to support consumer outreach activities starting in 2013, although a specific plan has not been developed.

Rhode Island recognizes that consumer assistance activities are an integral part of its broader approach to interacting with exchange users. To focus on this issue, the interagency exchange workgroup established a consumer support working group, consulted with a consumer assistance expert, and commissioned an analysis of the state's existing consumer assistance

infrastructure. In addition, the state identified a consultant to assist with designing the overall consumer support program, including outreach and education. One government informant noted that the state's vision for a consumer outreach program is a broad advertising and education campaign with a branding and marketing strategy to be operating by mid-2012. The consultant will likely engage with a broad spectrum of stakeholders for input as the program is developed.

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Given state budget constraints, Rhode Island is unlikely to offer additional subsidies for premium or cost-sharing assistance to individuals in the exchange.

PRIVATE MARKET REFORMS

Rhode Island is perceived as having a heavily regulated insurance market and, in 2004, became the only state in the nation to establish an office dedicated solely to regulating health insurance.⁴⁵ Created by a bill sponsored by the current lieutenant governor, the Office of the Health Insurance Commissioner has broad authority to regulate the health insurance industry and has introduced nationally recognized reforms to improve the affordability of coverage. Because of Rhode Island's history of health insurance regulation, some federal reforms under the ACA were already in place or were noncontroversial. However, other reforms that go into effect in 2014—such as coverage of an essential health benefits package—will fundamentally change the regulatory framework through which health insurance is sold and will likely require legislative action.

To date, Rhode Island has not passed legislation to implement the private market reforms included in the ACA. This is, however, not for lack of trying: members of the Rhode Island legislature introduced a bill that would have implemented the patient protections effective September 23, 2010, by requiring issuers to comply with the federal law and would have granted OHIC broad authority to adopt regulations and enforce these

provisions.⁴⁶ Though the legislature failed to pass that bill, informants suggested that these efforts will be renewed during the 2012 legislative session and may focus on passing conforming legislation, which would bring Rhode Island's code into compliance by passing each provision of the federal law. In the meantime, OHIC is working with an outside consultant to identify provisions in Rhode Island law that must be changed to conform to the market reforms of the ACA.

Issuers appear to have voluntarily come into compliance with the ACA's early market reforms with minimal prompting from OHIC.

Compliance with the Early Market Reforms

Issuers appear to have voluntarily come into compliance with the ACA's early market reforms with minimal prompting from OHIC. These early market reforms include a ban on preexisting condition exclusion periods and coverage denials for those under the age of 19, expanding dependent coverage up to age 26, eliminating lifetime limits and restricting annual dollar limits on EHBs,

and covering certain preventive services without cost-sharing, among others.⁴⁷ Informants noted that issuers were already complying with many of these protections, as required under state law or by practice, and that certain market reforms—such as annual or lifetime limits—are uncontroversial in the Rhode Island market because consumers are largely interested in “benefit rich” coverage and it would be difficult to sell coverage with such limitations. OHIC is also reviewing policy forms to ensure compliance and monitoring consumer complaints.

Informants did not suggest any particular challenges in coming into compliance with the early market reforms, and OHIC has received few, if any, consumer complaints about noncompliance. Issuers reported only a slight increase in premiums as a result of the early market reforms, and OHIC required issuers to justify this increase in 2010, which signaled that immediate compliance was expected by OHIC. Rhode Island has also avoided market disruptions in the child-only market and the regulatory challenges of monitoring grandfathered plans because BCBSRI, the only issuer in the individual market, agreed to continue selling child-only policies and stopped selling grandfathered plans.

Rhode Island’s High-Risk Pool

Though Rhode Island does not have a state high-risk pool, it coordinated with BCBSRI to administer the Pre-Existing Condition Insurance Plan of Rhode Island (PCIPRI), which is the temporary federal high-risk pool. Despite an active marketing campaign, PCIPRI enrollment has been low—only about 123 enrollees as of October 2011—which one informant attributed to the fact that high-risk individuals already had guaranteed access to the policies in the individual market. Indeed, about half the current enrollees in the individual market are considered high-risk.⁴⁸ Yet, even with low enrollment, informants report that medical claims have been much higher than BCBSRI expected: the issuer originally estimated it could serve 500 enrollees with its initial allocation of \$13 million but is now in monthly discussions with federal regulators to secure additional funding. Despite these financial concerns, the PCIPRI remains open to new enrollees and is being actively marketed.

2014 Market Protections—Policy Decisions

There seemed to be little concern that Rhode Island will come into compliance with the market reforms that go into effect in 2014. Legislation to address these reforms is expected to be introduced in the next legislative session. Informants note that some of the more significant 2014

market reforms are already in place. For example, in the small-group market, policies are offered on a guaranteed issue basis, without preexisting condition exclusion periods or consideration of health status. However, small-group carriers can vary rates based on age, gender and family composition within a four-to-one rate band,⁴⁹ which will have to be altered in light of the ACA, which restricts the use of gender for rating purposes and allows age as a rating factor only within a three-to-one rate band. In the individual market in Rhode Island, policies are also offered on a guaranteed issue basis for a limited time each year without a preexisting condition exclusion period.⁵⁰ However, premiums in the individual market are currently adjusted based on health status and age for low-risk enrollees with further adjustments permitted to subsidize high-risk enrollees; this will not be allowed under the ACA in 2014.⁵¹ Informants expressed concern that the adjusted community rating rules, along with the essential health benefits package required in 2014, could result in premium increases for low-risk enrollees, although premiums on average are not anticipated to rise as high-risk enrollees are expected to see decreases in premiums.

Stakeholders are engaged in ongoing discussions on policy issues related to the 2014 market reforms, but no final decisions have been made. Because many such decisions have implications for the exchange, the interagency exchange workgroup is involved in much of the analysis and research. One policy issue under discussion is whether to merge Rhode Island’s individual and small-group markets. A 2007 study suggested that merging the markets under existing small group law would cause an 11 percent increase and a 2 percent decrease, respectively, in average premiums in the individual and small-group market.⁵² Though Rhode Island declined to pursue a merger immediately following the study, the state will likely commission another study to determine if the markets can be merged in a way that avoids significant premium increases for low-risk individuals in the individual market.

Additional policy issues under discussion in both the exchange and private market context are risk adjustment, reinsurance and risk corridors.⁵³ Though no final decision has been made, the growing consensus among informants is that the state will make its own risk adjustment determinations.⁵⁴ To support this effort, Rhode Island has used its federal funding for rate review to build an all payer claims database, set to be operational by 2013. This database would strengthen both Rhode Island’s rate review process and the ability to perform

risk adjustment both within and outside the exchange. Reinsurance and risk corridors have also been discussed in the context of providing risk mitigation for newly engaged issuers in the individual market and limiting losses and gains of issuers in the exchange.

Other issues under consideration are how to fully implement the federal rating standards that go into effect in 2014, which will require legislative action, and next steps if Rhode Island's mandated benefits are not included under the federal definition of EHBs. Finally, OHIC may be exploring additional opportunities to encourage compliance with the 2014 reforms through the state's authority to review rates. For example, in its cycle two rate review grant request, Rhode Island requested funds to analyze the impact of the 2014 reforms on the rate review process.⁵⁵

Focus on Affordability: Rate Review and Medical Loss Ratio

Medical Loss Ratio. Rhode Island has a medical loss ratio (MLR) requirement in its small-group market but not its individual or large-group market and has not encountered market disruptions, adjustment requests or significant broker resistance because of the ACA's MLR requirements. Although Rhode Island does not specify a mandatory MLR in the individual market, BCBSRI is the only issuer and currently has an MLR that exceeds federal requirements. In the small-group market, issuers were already required to meet an MLR of 80 percent before enactment of the ACA. Industry informants indicated there were no difficult challenges in complying with the federal MLR standards because many were already meeting such standards, and broker compensation—an important part of the broker-mediated small-group market—was not affected by the federal requirement. OHIC expects to use the rate review process to determine whether an issuer is complying with the federal MLR requirements.

Rhode Island is a national leader in rate review and has established a comprehensive, transparent and innovative process.

Rate Review. Rhode Island is a national leader in rate review and has established a comprehensive, transparent and innovative process. OHIC's annual review of rates far exceeds a typical state rate review process, and OHIC views rate review as an opportunity to increase public awareness about how issuers set rates and implement

broader health care reforms in Rhode Island. To enhance these efforts, the state received two federal rate review grants in 2010 and 2011 totaling about \$4.75 million.

Rhode Island's rate review process was expanded in 2004 when the legislature established OHIC and directed it to review a unique set of rate factors including an issuer's activities related to improving affordability, quality and accessibility of medical care and the fair treatment of providers. Using this authority in 2009, OHIC implemented four affordability standards that the commissioner would consider when reviewing filings: 1) an increase in the issuer's proportion of medical expenses spent on primary care by 1 percentage point per year, 2) support for the expansion of Rhode Island's medical home initiative, 3) funding for the adoption and maintenance of electronic medical records, and 4) participation in ongoing dialogue on comprehensive payment reform. This authority has allowed OHIC to harness the power of rate review to address broader health care delivery system reform issues such as provider payment rates, differential pay between specialists and primary care physicians, and how to incentivize primary care.

To date, Rhode Island has very actively used its rate review authority to question premium rate increases. Rates in all three markets are reviewed by OHIC annually on a prior approval basis.⁵⁶ In the individual market, all rate filings receive a hearing under the state's mandated hearing process.⁵⁷ In the small- and large-group markets, the rate review process includes an initial review by OHIC, a public comment period, internal review, and, under certain circumstances, a hearing by OHIC.⁵⁸ In 2008, for example, OHIC noted that rate factor decisions resulted in consumer savings of at least \$15 to \$20 million. In addition, in 2009, issuers withdrew rate increase requests in the group markets after OHIC refused to approve any increase, called on insurers to withdraw their request and raised the possibility of future rate hearings if the rates were not withdrawn.⁵⁹ This withdrawal "effectively froze premium rates for six months."⁶⁰ The commissioner also refused rate increases in the individual market for all of 2009. Transparency in OHIC's rate review process is considered a critical aspect of its oversight strategy, and all rating decisions are posted online and made available to the press. The federal government has determined that Rhode Island's rate review process is only partially effective because policies sold through national associations are currently not reviewed by OHIC. As such, the federal government will defer to OHIC's decisions regarding the reasonableness of rate increases in the

individual and small-group markets but will review the rate requests for these types of association plans. Rhode Island is evaluating how to ensure that these plans are covered under the state's rate review process in the future.

Rhode Island is likely to continue to build on its successes in using its rate review process as a mechanism for reforming both the traditional health insurance market and the health care delivery system as a whole.

As noted above, Rhode Island received \$4.75 million in federal rate review grants. The cycle one grant award of \$1 million was received in September 2010 and used to hire additional staff; monitor implementation of affordability standards; improve data collection, analysis, and reporting; engage stakeholders; and work with the Department of Health on a study of the factors that increase health care costs in the state.⁶¹ The cycle two grant award of about \$3.75 million was received in September 2011 and is being used to support hiring of additional staff, develop a rate review policy and procedure manual, enhance data collection, and support a community organization that will partner with OHIC to generate interest and engage individuals and businesses in the rate review process. The cycle two grant is also being used, among other activities, to engage carriers in transforming Rhode Island's health delivery system through funding a study on hospital reimbursement and supporting the development of the all payer claims database to further OHIC's ability to analyze information on how health care dollars are spent.⁶²

Although informants admit that rate review alone will not address the underlying costs of care, the state has tried to use this process as an "affordability gate" to maintain at least some balance in its provider-dominant market. For example, in the face of highly publicized rate increase requests and hospital consolidation, OHIC released nonbinding hospital contracting conditions in 2010 that would be considered during a review of the issuer's contracts with hospitals as a mechanism to lower premiums.⁶³ The conditions include, for example, limiting the annual maximum price increase for inpatient and outpatient services to the CMS hospital price index.⁶⁴ In 2010, Care New England, one of Rhode Island's largest providers, filed a lawsuit against the health insurance commissioner arguing that the commissioner lacked the authority to issue contracting principles, interfere with Care New England's negotiations with United, and nullify a contract provision between BCBSRI and Care New England that threatened issuer solvency.⁶⁵ The first two issues were settled out of court; on the third issue, the court ruled in favor of the commissioner, whose use of regulatory authority to review and analyze provider contracts to evaluate issuer solvency was upheld. OHIC was pleased that its authority was intact but amended its regulations to include the hospital contracting conditions in 2011 because it had faced scrutiny for issuing the principles as nonbinding guidance.⁶⁶

Rhode Island is likely to continue to build on its successes in using its rate review process as a mechanism for reforming both the traditional health insurance market and the health care delivery system as a whole. As noted above, Rhode Island requested cycle two funds to analyze the impact of the 2014 reforms on the rate review process.

MEDICAID POLICY

Rhode Island expanded public coverage eligibility several times in the past two decades and now covers parents and children to fairly high income levels. Parents with incomes up to 175 percent of the federal poverty level (FPL) are eligible for Medicaid. Children and pregnant women in families earning 250 percent of FPL are eligible for public coverage as well, pregnant women through Medicaid, children through the Children's Health Insurance Program (CHIP) (a Medicaid plan in Rhode Island, CHIP is a Medicaid expansion program).⁶⁷ CHIP eligibility begins at 185 percent of FPL for infants, 133

percent of FPL for children ages 1 to 5, and 100 percent of FPL for children ages 6 to 19. Medicaid covers children below those income levels.

Almost all Medicaid recipients are enrolled in Rlte Care, the managed care program for children and families. The program has recently been extended to include the disabled. Rlte Care provides all the mandatory services required by Medicaid as well as a number of optional services. Currently, two insurers offer Rlte Care: Neighborhood Health Plan of Rhode Island and United.

Rite Care enrollment has been steadily increasing over the past decade. It increased from about 96,000 in 2000 to 132,000 in 2011. Medicaid enrollment overall grew from 144,700 in 2000 to 166,500 in 2010.⁶⁸

One of the most prominent aspects of Medicaid policy in Rhode Island is the Global Consumer Choice Compact waiver received in January 2009 and implemented in July 2009.⁶⁹ This 1115 waiver demonstration is funded under a federal cap, essentially a block grant. The state has the authority to spend up to \$12.1 billion in state and federal spending over five years, about 12 percent above its projection of \$10.5 billion.

Almost all Medicaid recipients are enrolled in RItE Care, the managed care program for children and families. The program has recently been expanded to include the disabled.

The waiver has been used primarily to consolidate several 1915(c) waiver programs and increase the community-based capacity of Rhode Island's long-term care system. Under the 1115 waiver, the state determines eligibility for long-term care services based on an assessment of a person's functional capacity. Persons who meet the highest level of care can access long-term care services and supports in either the community or in an institution, persons at the high level of care cannot access institutional services, and persons at the preventive level of care are able to receive limited home care.

Under the authority of the 1115 waiver, the state is also able to claim federal Medicaid matching fund for a range of services called "costs not otherwise matchable under the waiver" (CNOM). These were services related to health care but funded through state general funds. With the waiver, the state is able to get the federal government to share in these costs on the grounds that if people did not get services, they would become Medicaid eligible a lot sooner. Whether coverage of these services is sustainable is questionable. If the waiver is discontinued because it is not relevant post-2014, the state would be responsible for the costs of the CNOM, assuming it wanted to continue funding these services. Some of these costs would be covered under the Medicaid expansion, but others would become state responsibility.

The state may soon begin enrolling dual eligibles in Medicaid managed care. The state hopes that by placing the duals in managed care they would get the opportunity

to save money on this population, including receiving a percentage of the savings on Medicare benefits. It would also provide an alternative way of achieving the long-term care rebalancing that the state has been seeking.

Medicaid Managed Care

Two plans participate in the Medicaid managed care delivery system: Neighborhood Health Plan and United. The Neighborhood Health Plan is the largest plan, with enrollment throughout the state. It covers two-thirds of the Medicaid managed care market and 50 percent of the Medicaid population. The remainder are enrolled in United. The state has been aggressive about putting the disabled into managed care; almost all Medicaid beneficiaries other than dual eligibles are in managed care. Soon dual eligibles may be enrolled in managed care.

Medicaid managed care payment rates are considered reasonably good by the two participating plans. Developing rates has worked well for both the state and the plans, though obviously it is affected by budget considerations. In the past year, despite the seriousness of the recession, managed care rates were cut relative to cost trends but not in absolute dollars. Recent payment increases have been roughly around 2 percent a year.

One problem that Medicaid managed care plans have had is in negotiating rates with the state's two dominant hospital systems. The plans argued to the state that they have serious problems negotiating reasonable rates with these hospitals. The state now requires hospitals to accept rates increases tied to the growth in Medicare's hospital cost index. This constraint allows the plans to accept smaller increases in managed care plan rates.

The Neighborhood Health Plan is considering whether to participate and compete in the exchange. Its biggest immediate priority is competing for dual eligibles when the managed care for duals begins. The plan also has concerns over whether it has the financial and operational capacity to participate in the exchange. The Neighborhood Health Plan has been a strong proponent of the BHP as an option. If BHP were adopted, it would reduce the likelihood that the Neighborhood Health Plan would participate in an exchange. United already participates in the commercial markets and will likely participate in the exchange, with or without a BHP. BCBSRI indicated that it intends to re-enter the Medicaid market, if the state permits, as well as the exchange.

The Recession

The state has been under budget pressure because of the recession, though helped by the increases in federal matching rates from the American Recovery and Reinvestment Act (ARRA). The primary response to the recession was to cut payments to managed care organizations, hospitals, and nursing homes. There were also cuts in payments for services provided to individuals with developmental disabilities. The waiver has allowed the state to move previously state-funded services into Medicaid and obtain federal matching funds. This has provided fiscal relief to the state, lessening the need for other cutbacks. The state has really never been able to spend at the level allowed by the waiver, which requires state matching funds.⁷⁰ This means that with the recession, the state still had to make cutbacks and was not able to avail itself of all the available federal money.

Because of the recession, the state wanted to increase premiums for those with incomes above 150 percent of FPL. The limit currently is at 3.3 percent of family income; the state wanted to increase the premium to 5 percent, viewing increases in premiums as a better alternative than cutting eligibility (which was prohibited by ARRA and ACA and for which there would have been a lot of opposition within the state). Federal regulators denied the state's request.

The state is an active user of provider taxes: there is a licensing fee on hospitals and provider taxes on managed care plans, nursing homes, and home health agencies. Initially, hospitals and nursing home taxes were offset through rate increases. This has been less true more recently. The imposition of provider taxes has clearly helped the state get through the most recent recession.

If there is a federal limit on provider taxes as part of deficit reduction, the state could be adversely affected.⁷¹ The state would have to come up with more revenues in order to achieve the same level of payments to providers. This issue is starting to loom but is not something the state is now focused on.

The Affordable Care Act

In Rhode Island, the insurance coverage expansions made available under the ACA will primarily affect childless adults because of Rhode Island's current coverage of parents and children. It is expected that most individuals with income above 138 percent of FPL who are now covered by Medicaid would be covered under an exchange plan or the BHP, if adopted. This includes

parents, pregnant women and the medically needy with incomes above 138 percent of FPL.

Medicaid officials believe that managed care plans in the state have the ability to serve the larger population that will come in the program with health reform. The managed care plans rely on community health centers to a considerable extent. There are more concerns about capacity to provide behavioral services. The state anticipates that many new enrollees will have behavioral health issues, and they are concerned about the state's ability to provide for those increased needs.

The state is anticipating the temporary increases in Medicaid fees for selected services called for in the ACA. Since most care to the Medicaid population is provided by managed care plans, Rhode Island is anticipating providing a simple add-on to rates to pass through the added cost of these higher physician payment rates. Whether rate increases will continue after 2014 will depend on state finances.

The Basic Health Plan

As noted above, there is a great deal of support for the exploring the development of a BHP within state government. A BHP may make health care more affordable and easier to integrate with Medicaid/CHIP. The main concern centers on financial risks to the state: will the federal payments be sufficient to pay for a basic health plan without exposing the state to new expenditures. Consumer groups have been advocating heavily for BHP. The state has indicated a willingness to explore the BHP option but not at the cost of losing high-quality coverage for children and parents currently

The main concern centers on financial risks to the state: will the federal payments be sufficient to pay for a basic health plan without exposing the state to new expenditures.

covered under Rite Care. The Neighborhood Health Plan, the largest Rite Care plan, has been actively supportive of a BHP; hospitals, on the other hand, are opposed because that would mean more patients for whom they would be reimbursed at Medicaid rates.

On the issue of whether BHP would mean that exchanges could be too small, the state will ultimately rely on analysis by consultants to advise them. But in general,

Rhode Island expects the exchange to work very closely with Medicaid in terms of establishing market leverage. The state sees the exchange and Medicaid as working

together to align policies as appropriate. Informants recognize that Medicaid and exchange plans and benefits will differ somewhat.

PROVIDERS AND INSURERS

Once health reform is launched and individuals gain insurance coverage, the success or failure of reform will greatly depend on the response of providers and insurers. How these systems respond will affect coverage, access to care, premiums, subsidy costs and, ultimately, the sustainability of health reform.

Hospitals

There are two dominant hospital systems in the state. Rhode Island Hospital is a major teaching center and is in a system with several other hospitals. Care New England is a maternity hospital that provides 85 percent of the state's deliveries. Seven of the state's 11 hospitals are in these two systems. No one can realistically sell an insurance product without these two systems participating. It is therefore very difficult for insurers to really effectively compete to be "a second lowest cost plan" by excluding high-cost hospitals from their networks. All hospitals in the state provide services to Medicaid and the uninsured, but these systems are clearly the most dominant. As noted earlier, these two systems have enormous clout vis-à-vis health plans.

The court recently ruled in favor of the commissioner, whose use of regulatory authority to review and analyze insurer contracts with providers was upheld.

While many worry about the power of the two main systems, the hospital association believes that hospitals in Rhode Island in general are doing poorly because of the large number of uninsured people and low Medicaid payment rates. Hospitals have been affected adversely by the recession because of the reduced demand for services. There are also concerns about the effects of the Medicare cuts in the ACA because Rhode Island has an older population. Hospitals will also be affected by reductions in Medicaid disproportionate share payments. This will particularly affect hospitals that have a large share of Medicaid business, primarily Care New England. The hospital association believes that cuts in payments from various sources will be much greater than the increase in revenue from having more insured people.

Although supportive of expanding health insurance, the hospital association does not expect it to be good for hospitals. The association argues that hospitals have little control over some major elements of costs. Union contracts constrain their ability to control labor costs, and utility costs are high throughout New England.

Insurers

As noted above, BCBSRI, Tufts and United are the only significant commercial insurers, and all are likely to participate in exchanges. Neighborhood Health Plan is a possibility, but it has concerns that were mentioned above. Many in the state do not see an advantage in having a lot of competing plans striving to be the second lowest cost plan. The reality is that Rhode Island has a provider-dominated system, and more plans with little leverage over providers will not solve the cost problem.

The health insurance commissioner has authority to review premium increases by insurers. Insurers, as noted, have difficulty negotiating with the two largest hospital systems. Starting in 2008, the commissioner asserted his authority to review insurer contracts with hospitals during the rate review process. In addition, in 2010, the commissioner issued contract conditions, such as limiting the annual maximum price increase for inpatient and outpatient services to CMS hospital price index, to be considered during the review process.⁷² Hospitals demanding the biggest rate increases had these contracts scrutinized by the commissioner. As noted above, Care New England sued the state, contending that the commissioner had gone beyond his authority. The court recently ruled in favor of the commissioner, whose use of regulatory authority to review and analyze insurer contracts with providers was upheld.

The commissioner also required insurers to increase the amount of money spent on primary care beginning with 6 percent of the premium going to primary care services and increasing it to 11 percent over five years. The state expanded their all-payer patient-centered medical home initiative and increased incentives for electronic health record adoption.

The insurance commissioner and other observers would like to encourage Harvard Pilgrim and Fallon Community

Health Plan in Massachusetts to enter the exchange market. They argue that more carriers in the exchange would enhance health plan competition and employer and individual choice, although more carriers would probably significantly affect premiums given the delivery system issues cited above. It would also be helpful to have Neighborhood Health Plan come in. The commissioner believes that with reinsurance in place, it limits the risks that Neighborhood Health Plan would face, reducing necessary reserve requirements. Again, the issue seems to be that all plans have essentially the same provider networks. All face problems in negotiating with the major hospitals, and new plans would face the same problem. Thus, more competition could mean better service, better care management and more efficient administration, but it is not likely to affect provider payments.

From the state's perspective, hospitals purchasing physician practices would be counterproductive. Initiatives such as the all-payer primary care medical home program are designed to keep people out of hospitals.

Physicians

Physicians are largely organized in small practices; there are a handful of larger practices, but by and large they are exceptions. The physicians feel under a lot of pressure in negotiating with insurers; unlike hospitals, they bring little weight to the negotiating table. As a result, physician fees are thought to be relatively low by national standards.

There is a view that physicians will need to move away from these small practices to take advantage of economies of scale, adopt electronic health records, conduct e-prescribing, and so on. Unless physicians respond to the need to practice more efficiently, including making practices more electronic, they will not survive; thus, there is a need to merge and share capital expenditures.

Both the medical society and hospital association do not see a large expansion of physician practices being purchased by hospitals. There was an effort in this direction in the early 1990s, but by the middle of the decade hospitals were attempting to divest themselves of those practices because they had little experience managing primary practices. Hospitals are trying to develop primary care operations, but they have not been aggressively acquiring practices or setting up new

practices. Private physicians in Rhode Island are wary of being part of hospitals. The argument in favor is that hospitals would be able to negotiate with insurers on behalf of physicians better than physicians can do on their own. If insurers increased rates paid to primary care doctors, it would make it less attractive for physicians to be acquired by hospitals.

From the state's perspective, hospitals purchasing physician practices would be counterproductive. Initiatives such as the all-payer primary care medical home program are designed to keep people out of hospitals. If hospitals do successfully align with physician practices, absent reforms emphasizing population-based payments, it is likely that a major incentive will be to keep beds filled, a move in the wrong direction.

Physician groups have been supportive of most delivery system reforms that are coming about because of the Affordable Care Act. They believe all the efforts are potentially useful. No one knows what is likely to be the most successful, thus they are supportive of trying a lot of different approaches. Physicians groups believe that physicians will be at the heart of delivery system change. It is believed that physician practices will have to evolve to be larger, and there will need to be more coordination among nurses, physician assistants, social workers, and doctors. Physicians will have to act more as managers than they do today. Many doubt that the accountable care organization model would work in Rhode Island. It requires such a fundamental reorganization of physician practices and alignments with hospitals that it does not seem likely to succeed.

Primary Care Capacity

There is some debate in the state over the adequacy of primary care capacity to deal with increased demand. Some believe there is a sufficient capacity. Others believe there is a primary care shortfall and, if it is to be solved, it will be through changes in practice patterns. Physician practices need to get larger and be more efficient in the way they use physician assistants and nurse practitioners. Further, the system needs to move to physicians focusing on the kinds of care they are trained for, not on what physician assistants are capable of doing. They argue that not only are there not enough physicians but there is also a shortage of nurses.

State officials believe their patient-centered medical home initiative could result in smaller practices seeing financial incentives for becoming primary care medical homes. This will lead to more affiliation among primary

care practices. Officials believe that the medical home model will drive this consolidation, not purchases of practices by hospitals. Many respondents expect that a great deal of the provision of care to newly insured people will be done by community health centers located where low-income people live.

Rhode Island is pushing forward a progressive multipayer patient-centered medical home (PCMH) model, the chronic care sustainability initiative (CSI RI), with great support from state officials as well as the primary care community. CSI RI is run through OHIC and incorporates all major payers in the state except Medicare fee-for-service. The pilot project will span from October 2008 until March 2012 and includes 13 practices and 70,000 patients. The medical homes are paid on a fee-for-service basis with an additional flat per capita fee each month. The CSI RI program will use claims-based data to determine the effectiveness of the care delivery model. In addition to the CSI RI pilot project, Rhode Island has seen a great uptake of PCMH practices around the state. A recent study reports that Rhode Island has the highest

number of physicians per capita practicing medicine under the PCMH model.⁷³ Additionally, the PCMH initiative in Rhode Island has received national recognition from the National Committee for Quality Assurance, which ranks the state eighth in the country for the number of physicians involved in PCMHs.

Business

The business community is generally supportive of health reform. There has been a rapid increase in insurance premiums for small businesses in recent years. As a result, while there was some initial opposition, small businesses are now positively disposed toward health reform and are actively involved in many of the state's working groups. Many small businesses are vocal and want the exchange to be a very active purchaser so it can control costs. The Rhode Island Business Group on Health assigned a business person to every one of the workgroups, and they have been active participants. The largest businesses are not part of these discussions because they are self-insured do not see the reforms as affecting them significantly.

SUMMARY AND CONCLUSIONS

Rhode Island is off to a strong start in implementing the Affordable Care Act. Its success thus far has resulted from strong leadership and commitment to health reform at the highest levels of government. The state benefits from close and effective working relationships among its leadership. Rhode Island also benefits from its small size with few insurers, providers and other stakeholders. Through an open process, stakeholders have been able to participate throughout the process of developing the exchange and implementing other aspects of reform.

Rhode Island has been actively working toward establishing an exchange since the spring of 2010. When legislation for a quasi-public state exchange failed over a dispute about abortion coverage, Rhode Island's new governor signed an executive order establishing the exchange. The major disadvantage of housing the exchange as a division within the Executive Department, as opposed to being a public corporation, seems to be in staffing and procurement, although steps have been taken to mitigate these concerns.

Planning for the exchange is continuing, and a number of key decisions have been made. For example, Rhode Island has established a governance model, including

Overall, Rhode Island is moving forward with health reform and will likely continue to play its role as a nationally recognized leader in ACA implementation.

an advisory exchange board, with standards for public accountability and transparency and avoidance of conflict of interest. The state has pursued all available federal funds and has received a planning grant and a level one establishment award; Rhode Island was also the first state in the nation to receive a three-year level two establishment award. A number of studies and projects have been completed, and more are planned to inform future exchange decisions.

A number of policy decisions appear inevitable even if not officially approved by the governor. First, there appears to be consensus that the exchange will help serve a large share of the population, not just those who are currently uninsured, to understand their health insurance options. A subset of this population will receive health insurance through the exchange, whether through subsidized or

unsubsidized private coverage or Medicaid. Second, the state seems likely to adopt an exchange model with at least some type of active purchasing role. The state has made major steps toward finalizing its vision for an eligibility and enrollment system—which integrates eligibility, enrollment and other functions for Medicaid, the exchange plans and other human services programs—and developing a plan for procuring the information technology to support it. At the same time, many important decisions have yet to be made, such as the design of the SHOP exchange, whether to standardize benefits, how to finance the exchange and whether to adopt the basic health plan.

Although the future of Rhode Island’s mandated benefits was expected to be a particularly controversial issue, recent federal guidance on EHBs may afford Rhode Island, at least in the near term, an opportunity to sidestep this issue.

Although the state has yet to pass new legislation implementing the market reforms of the ACA, it has moved rapidly to ensure that issuers comply with the early market reforms of the ACA. Many of these protections were in place, either by practice or as required by existing state law, before passage of the ACA. Issuers appeared to have very little difficulty in complying with those not already in place. In addition, Rhode Island has a comprehensive rate review process that the health insurance commissioner has used to aggressively examine rates and attempt to address affordability of coverage, including implementing affordability standards and reviewing issuer contracts with hospitals.

There seemed to be little concern that Rhode Island will come into compliance with the market reforms that go into effect in 2014, especially since a number of the more significant protections, such as guaranteed issue, no preexisting condition exclusion periods and adjusted community rating, are either in place or partially in place in the individual and small-group markets. Legislation is expected to be introduced in the next legislative session to ensure that Rhode Island is in full compliance with the 2014 market rules. However, there are policy issues related to the 2014 market reforms, such as merging the individual and small-group markets and whether Rhode Island will conduct its own risk adjustment mechanism, where final decisions still have to be made. Continued

research, analysis and discussions with stakeholders are expected to inform these decisions.

The Medicaid expansions in recent years mean that the public coverage expansion provisions in the ACA will only affect childless adults. Rhode Island already extends coverage to parents and children above ACA levels. Many, if not most, of those with incomes above 138 percent of FPL who are currently covered in Medicaid are likely to enroll in exchange plans. The state believes it has the managed care capacity to handle the new enrollment.

A major issue in health reform implementation in the state is whether to adopt the BHP. There is a widespread agreement that the BHP would make health care more affordable, and there is strong support for it among consumer advocates. The Neighborhood Health Plan, the largest managed care plan in the state, is an active supporter of the BHP. Hospitals, on the other hand, are opposed because they are concerned about low Medicaid payment rates, an issue that the state disputes.

Rhode Island faces problems with health care cost growth, like other states. It has two dominant hospital systems that have considerable market clout with respect to private payers. The insurance commissioner has intervened through his rate-setting authority to constrain the growth in insurer payments, both in the commercial market and in Medicaid, to these dominant hospitals.

There are concerns about primary care capacity. It is expected that federally qualified health centers will play a major role in meeting the new demand for care. It is not expected that primary care capacity will expand through hospitals purchasing private practices. There is some hope that physicians will form larger groups and increase their use of ancillary personnel.

In general, the business community has been supportive of reform. While there was some initial opposition, small businesses are now active supporters, primarily because of the hope that reform will control their insurance premium costs.

Overall, Rhode Island is moving forward with health reform and will likely continue to play its role as a nationally recognized leader in ACA implementation.

About the Authors and Acknowledgements

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NOTES

1 Rhode Island Executive Order 11-04, January 13, 2011.

2 All data in this paragraph are from the Urban Institute's Health Policy Simulation Model, or HIPSM.

3 2011 Rhode Island Senate Bill No. 87.

4 Rhode Island Healthcare Reform Commission Executive Committee. "New Options for a Rhode Island Exchange." Presentation, July 8, 2011.

5 2011 Rhode Island Senate Bill No. 87. Under proposed R.I. Code § 42-154-11, the bill would have required the following: "The functions and operations of the exchange shall not expand beyond the minimum requirements of the federal act."

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10 Rhode Island Executive Order 11-09, § 7.

11 Compare 2011 Rhode Island Senate Bill No. 87 ("The functions and operations of the exchange shall not expand beyond the minimum requirements of the federal act.") with Rhode Island Executive Order 11-09 ("The RIHBE shall, *at a minimum*, carry out the functions and responsibilities required under the Affordable Care Act") (emphasis added).

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