

Wakely
Consulting Group



Assessment of the Basic Health Plan Opportunity in Rhode Island

November 18, 2011

Table of Contents

INTRODUCTION	3
COVERAGE IMPLICATIONS OF A BHP IN RHODE ISLAND	3
KEY FACTORS	4
FINANCIAL MODELING	10
RESULTS	11
DISCUSSION AND RECOMMENDATIONS	14
APPENDIX: METHODS AND ASSUMPTIONS	16

Introduction

The Affordable Care Act (ACA) offers states the option of creating a Basic Health Program (BHP) to provide coverage for Medicaid-ineligible individuals with incomes up to 200% of the Federal Poverty Level (FPL). These individuals would otherwise have been covered through exchange-based tax credits. States electing a BHP would contract with one or more health plans offering at least the level of coverage required of plans provided through exchanges.

To be eligible for a BHP, state residents must be under age 65, and not eligible for Medicaid or other minimum essential coverage or for employer-sponsored coverage that is “affordable,” as defined by the ACA. Individuals must have incomes between 133 and 200% FPL.¹ Lawfully present aliens who are not eligible for Medicaid and who have incomes below 133% FPL are also eligible. In a state with a BHP, individuals eligible for the BHP are not eligible for the exchange.

A state choosing to establish a BHP would receive federal funding equal to 95% of the premium and 100% of the cost-sharing tax credits² that BHP members would have received had they purchased coverage through the exchange.

The decision whether or not to create a BHP is an important one for Rhode Island. Wakely was asked to assess the BHP opportunity, to help the state understand its potential effects, and to model the potential financial impact of the BHP.

Coverage Implications of a BHP in Rhode Island

Rhode Island’s subsidized health coverage program, Rite Care, already covers children up to 250% FPL and parents up to 175% FPL. Without a BHP, in 2014, Rite Care would continue to cover children up to 250% FPL in Rite Care. Adults (childless adults and parents) up to 133% FPL would be covered through an expanded Rite Care program. Adults with incomes from 133-400% FPL would be eligible to purchase subsidized health insurance through the exchange.

If Rhode Island were to establish a BHP, the vision would be to integrate the program with Rite Care. This means that the program would be seamless to enrollees, whether they are enrolled through BHP, Medicaid, or CHIP. Current Medicaid MCOs would be the most likely carriers. Under this integrated vision of the BHP, adults up to 200% FPL would be covered through Rite Care. Adults from 200-400% FPL would be eligible for subsidized insurance through the exchange. Children up to 250% FPL would remain in Rite Care.

These options are shown in Figure 1.

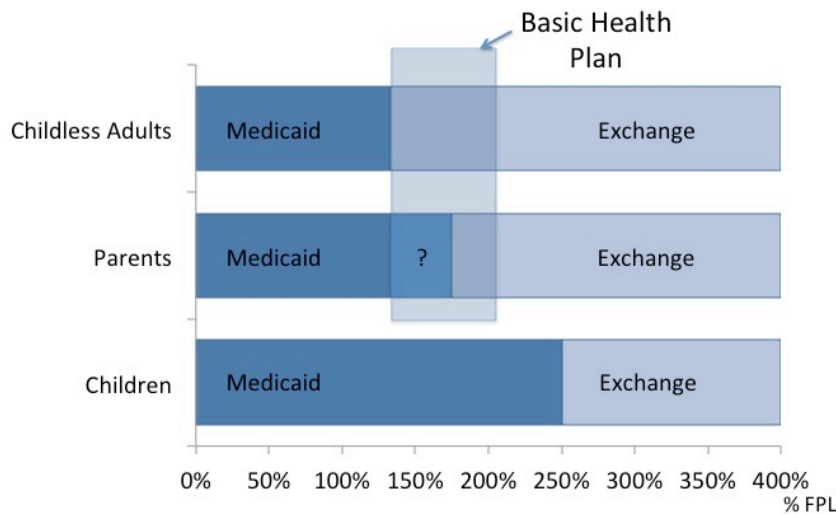
RiteCare also covers pregnant women up to 250% FPL. For purposes of simplicity in modeling and analysis, BHP eligibility was based on income alone in our financial model. This means that pregnant women were not analyzed as a distinct category. We also did not specifically analyze coverage for

¹ The ACA sets the eligibility threshold at 133% FPL but provides for an additional 5% income disregard, creating an effective eligibility cut-off of 138% FPL. Data used in our analysis was based on a 133% FPL cutoff, to be consistent with state modeling of the BHP population.

² The statute is ambiguous as to whether the federal government will pay 100% of 95% of the cost-sharing credits. This is one of several issues that will need to be clarified. Our model assumes 100% of cost-sharing credits.

disabled populations in our initial financial model. More refined analyses in the future will be helpful to better understand the implications of coverage for these populations.

FIGURE 1. COVERAGE IMPLICATIONS OF A BHP



Key Factors

To better understand the benefits and risks of a BHP for Rhode Island, Wakely assessed the impact of the BHP on low-income populations, the impact on the viability of the exchange, and the potential for carrier participation. In addition, Wakely developed a detailed model to provide financial projections of the potential costs associated with a BHP.

1. Impact on Low-Income Populations

The BHP serves a low-income population. Low income populations may be particularly affected by health policy changes and decisions, in part because they have less access to employer sponsored insurance and also because at lower income levels, a small change in household expenditures could have more significant impacts. It is therefore particularly important to carefully consider the impact of a BHP on this population. We looked at three different aspects of this impact: affordability, the impact on families, and churning.

a. Affordability

In looking at affordability, the state should consider the amount that members are expected to contribute toward premiums and cost-sharing in an exchange plan, and compare that with the amount a member would potentially contribute under a BHP. The state will of course have flexibility in defining member contributions toward a BHP, but for the purposes of comparison we examined (1) amounts that members currently contribute under Rite Care and (2) a “5%” premium

contribution that was used in our financial model (5% of income except where this exceeds the maximum amount allowed by ACA).

At most income levels, expected individual contributions to exchange premiums are comparable to or slightly less than current Rite Care premiums. However, families in the exchange may be hard hit by an exchange plan: if they are expected to pay a separate premium for their child to participate in Rite Care, then their total premium contribution would be higher in the exchange than currently in Rite Care.

In addition, Rite Care does not require additional cost-sharing, which is allowed in exchange plans.

TABLE 1. POTENTIAL COSTS TO ENROLLEES UNDER EXCHANGE AND RITE CARE COVERAGE

Single		Exchange (2 nd Lowest Silver)		RiteCare		BHP Model Assumptions ⁵	
FPL	Monthly Income	Monthly Premium	Monthly Max OOP	Monthly Premium	Monthly Max OOP	Monthly Premium	Monthly Max OOP
133%	\$1,244	\$37	\$30	\$0	\$0	\$37	\$0
150%	\$1,402	\$56	\$30	\$61	\$0	\$56	\$0
175%	\$1,636	\$84	\$65	\$61	\$0	\$82	\$0
200%	\$1,870	\$118	\$65	\$77	\$0	\$93	\$0

Family of 3		Exchange (2 nd Lowest Silver)		RiteCare		BHP Model Assumptions ⁵	
FPL	Monthly Income	Monthly Premium	Monthly OOP	Monthly Premium	Monthly Max OOP	Monthly Premium	Monthly Max OOP
133%	\$2,116	\$63 (+\$0 child)	\$30	\$0	\$0	\$63	\$0
150%	\$2,386	\$95 (+\$61 child)	\$30	\$61	\$0	\$95	\$0
175%	\$2,784	\$143 (+\$61 child)	\$65	\$61	\$0	\$139	\$0
200%	\$3,182	\$200 (+\$77 child)	\$65	\$77	\$0	\$159	\$0

Key assumptions:

1. 1% annual inflation rate for FPL.
2. In exchange, premium not to exceed 3% of income at 133% FPL, 4% at 150% FPL, 5.15% at 175% FPL, and 6.3% at 200% FPL, for the second-lowest cost silver plan.
3. Silver plan in exchange provides 70% AV and costs \$411 per month for individual coverage. Methods and assumptions for the calculation of the silver rate are detailed in the Appendix.
4. Rite Care member premiums and cost-sharing are the same as 2011 levels.
5. Estimated BHP costs shown here and used in our financial model in the second part of this report were set at 5% of income except where this exceeds limits set by ACA.
6. A family of 3 is assumed to be one adult and two children.
7. For the exchange scenario, we show the additional cost of enrolling children into Rite Care in parentheses.

Considering premium contributions only (without including cost-sharing contributions), we calculated expected premium contributions through the exchange for the second lowest-cost silver plan and through Rite Care as a percentage of income for individuals and for families of 3. We also estimated the cost of the lowest-cost silver plan, assuming that the single premium of the lowest cost silver plan is \$20 per member per month (PMPM) less than the cost of the second lowest plan, and assuming that a family premium is \$50 PMPM less.

These percentages are shown in Figures 2 and 3 below. Importantly, generally lower contribution levels in the Rite Care program create a step-up at 200% FPL, particularly for families, which may cause “sticker shock” for those transitioning between Rite Care and the BHP or Exchanges. If the state were to maintain low or no premium and cost-sharing contributions for lower-income populations (for example, the population below 150% FPL), this could also contribute to crowd-out of private insurance.

FIGURE 2. MEMBER PREMIUM CONTRIBUTIONS AS PERCENTAGE OF INCOME, INDIVIDUALS

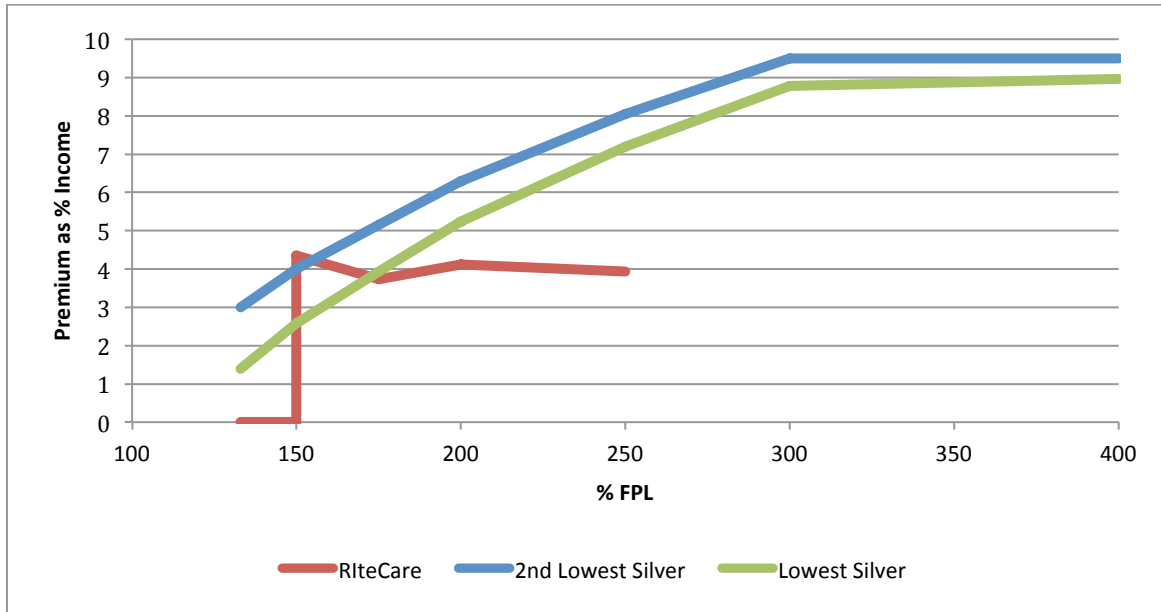
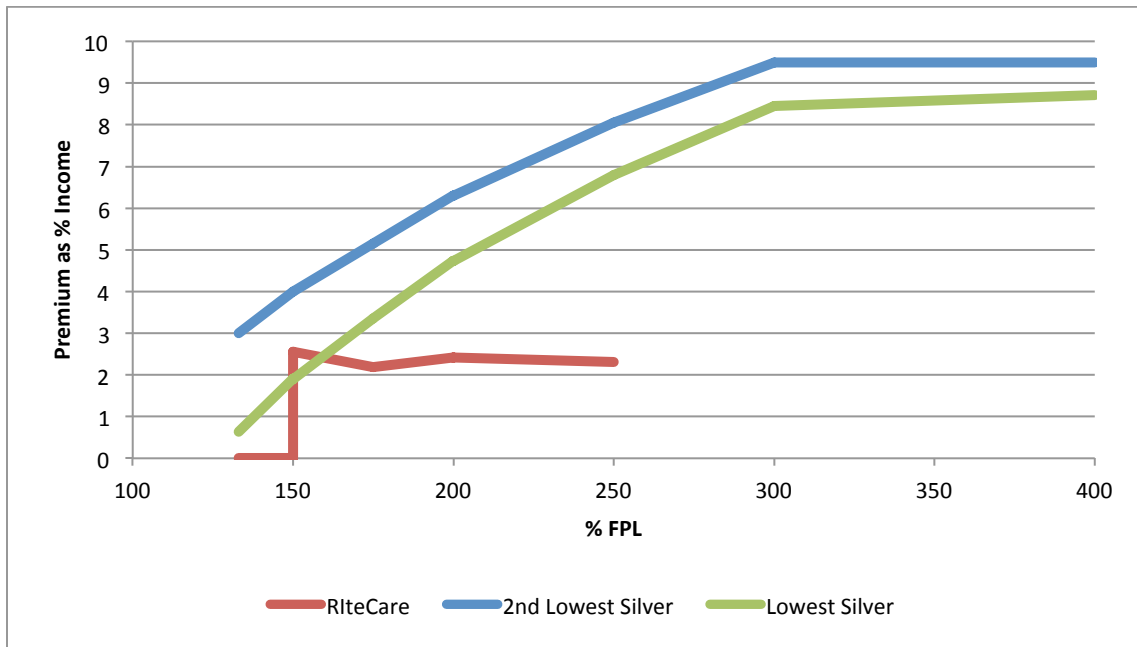


FIGURE 3. MEMBER PREMIUM CONTRIBUTIONS AS PERCENTAGE OF INCOME, FAMILY OF 3



In summary, Rite Care costs to members are generally lower than potential Exchange costs, if both member cost-sharing and premium contributions are taken into account. However, these differences would be partly mitigated if the lowest cost silver plan were significantly less expensive than the second lowest cost plan. If the state chooses to implement a BHP and maintains a contribution model patterned on Rite Care, policymakers should be cognizant of the discontinuity that could occur at 200% FPL when families transition from BHP to the exchange.

b. Impact on Families

Children in families with incomes below 250% FPL are currently covered by Rite Care, with funding through the CHIP program. The ACA requires states to maintain current income eligibility levels for CHIP through September 30, 2019. We expect therefore that children in families with incomes below 250% FPL will continue to be covered through Rite Care. This means that covering parents with incomes up to 200% FPL through Rite Care (funded through the BHP) has the advantage of enrolling families in the same plan. Research has shown that dropout rates are significantly lower when children and parents are both enrolled in coverage.³

In the absence of a BHP, parents from 133 to 200% FPL would purchase coverage through an exchange. If MMCOs participate in the exchange, then the parent would have the option of remaining with the same carriers (Neighborhood or United). However, there would be less integration, and more plan choice, than if the entire family were in Rite Care, issued one card and paid one premium.

c. Churn

Integration between Medicaid, CHIP and the BHP is appealing because of its potential to decrease the frequency and adverse impact of changes back and forth between coverage programs, a problem sometimes referred to as “churning.” Churning can occur due to changes in eligibility with changes in income, such as when an enrollee’s income increases and he/she becomes ineligible for coverage through a particular subsidized program. Research has shown that disruptions in insurance coverage have adverse effects on health care access and administrative costs.⁴

There is evidence to suggest that churning will be a significant problem under health reform. Previous research found significant income fluctuations in the low-income population that will be served by Medicaid and by exchanges under health reform. In a 12-month period, 50% of adults with incomes below 200% FPL were found to experience a change in income that would have affected their eligibility.⁵ The population between 133 and 199% FPL may be particularly prone to income fluctuations: an analysis of survey data from 2005-2006 found that only 51% of adults between 133-199% FPL remained in the same income category at the end of one year, compared to

³ Sommers BD. Insuring children or insuring families: do parental and sibling coverage lead to improved retention of children in Medicaid and CHIP? *J Health Econ* 2006;25:1154-69.

⁴ Weissman JS, Stern R, Fielding SL, Epstein AM. Delayed access to health care: risk factors, reasons, and consequences. *Annals of Internal Medicine*. 1991; (114): 325-331; Ku L, Ross DC. Staying covered: the importance of retaining health insurance for low-income families. Washington, DC: Center on Budget and Policy Priorities.

⁵ Sommers BD, Rosenbaum S. Issues in health reform: how changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Affairs*. 2011; 30(2): 228-236.

76% of those with incomes below 133% FPL and 73% of those with incomes between 200-399% FPL.⁶

The available evidence to date suggests that there will be high levels of income volatility at both 133% FPL and 200% FPL. However, the higher eligibility transition point does change who is churning. One reason policymakers might consider selecting a higher cutoff is the availability of other sources of coverage. For example, individuals at higher income levels are more likely to be eligible for employer sponsored insurance (ESI) and to participate in health insurance plans when offered.⁷ Under health reform, individuals with ESI available to them would not be eligible for subsidized insurance through the exchange or the BHP, as long as that ESI is considered affordable. Thus, it is possible that there may be fewer people affected by changes in program eligibility at 200% FPL because more of these individuals would be covered through ESI and not utilizing Medicaid, the BHP, or subsidized exchange plans.

2. Impact on Exchange Viability

Electing a BHP has important implications for the exchange. Operating a BHP would reduce enrollment in qualified health plans (QHPs) through the Exchange, which affects the scale of the exchange. Another important consideration is the demographic and health characteristics of the BHP population and the remaining exchange population.

a. Scale

Estimates from the state suggest that the total size of the individual exchange will be 64,000. This includes 19,000 individuals who would be BHP-eligible, an additional 25,000 with subsidized coverage, and 20,000 with unsubsidized coverage. In addition, the SHOP exchange is estimated to have an anticipated take-up of 17,000.

Operating a BHP would reduce enrollment in qualified health plans (QHPs) through the Exchange. This could pose challenges to the exchange's scale and viability; however, the state is considering revenue models that take into account services provided by the exchange not just to QHP enrollees but also to other "customers" of the exchange. For example, the state estimates that 845,000 people will shop through the exchange (even if they do not ultimately purchase an exchange plan) and 256,000 may use the exchange to determine eligibility, as shown in the figure below.

⁶ Short PF, Swartz K, Uberoi N, Graefe D. Realizing health reform's potential: maintaining coverage, affordability, and shared responsibility when income and employment change. New York: Commonwealth Fund; 2011.

⁷ DeVaney SA, Anong ST. The likelihood of having employer-sponsored health insurance. Compensation and Working Conditions. 2007 Nov 30.

Anticipated Use/Volume of Exchange, Post-2014



If the state were to pursue a BHP, we agree that it should investigate a funding mechanism whereby the BHP would pay the exchange a small user fee (on behalf of its enrollees), reflecting the role of the exchange in providing eligibility determination (and potentially an on-line plan selection tool) for BHP enrollees. This funding structure would help ensure adequate operating revenue even with a BHP reducing the number of individuals enrolled in QHPs.

b. Health Status

Understanding the health status of the BHP population, relative to the remaining exchange population, is important for modeling the viability of a BHP. If the BHP population is significantly healthier, then premiums in the exchange will go up. Similarly, if the BHP population is much sicker, then costs of the BHP will go up, premiums in the exchange will go down, and federal subsidies, which are pegged to the cost of premiums in the exchange, will presumably decrease unless there are risk adjustment measures in place.

It is not possible to predict with complete certainty the exact composition of who will actually enroll in a BHP or exchange. However, we used two approaches to approximate, at the population level, the health risks of the potential BHP and exchange populations.

First, Rhode Island data from three years (2008-2010) of the Current Population Survey was analyzed to determine a relative health risk of the 133-200% FPL population versus the 200-400% FPL population. Among those with non-group insurance, the 133-200% FPL population is healthier than the 200-400% FPL population. Among the uninsured, the lower income group is less healthy. Overall, among all non-group and uninsured, the health of the 133-200% FPL and 200-400% FPL populations is similar.⁸

Second, we analyzed recent data from a comparison population and assessed the health status and demographic risk of enrolled members with incomes between 100-200% FPL and 200-300% FPL. There was no significant difference detected in the health risk of the 100-200% FPL population compared to the 200-300% FPL group. There was slightly higher demographic risk (age/gender) in the 200-300% FPL population when compared to the 100-200% FPL population.

Overall, these two analyses suggest that there is unlikely to be a significant risk difference between the BHP and exchange populations. **This suggests that a decision on the BHP is unlikely to have a**

⁸ Personal communication from Dr. Jonathan Gruber, June 7, 2011.

significant impact on the health risk of the exchange. Furthermore, these preliminary analyses decrease the concern that the health risk of the BHP population would erase the margin between the subsidy dollars provided by the federal government to support the BHP and Medicaid Managed Care Organization (MMCO) rates.

These analyses have important limitations, however. The first analysis looks at state-specific data, but does not account for the possibility of differential take-up (i.e., that sicker individuals may be more likely to seek coverage). It also focuses on the uninsured and those with individual insurance, and would not account for those who currently have other forms of insurance (such as Medicaid or ESI) who may also come into an exchange or BHP. The second analysis uses data from another state, which may not be representative of the Rhode Island experience, and uses an income cutoff of 100% FPL, rather than the 133% FPL cutoff under the ACA. These analyses also do not account for any potential impact of the legal immigrant population with incomes below 133% FPL. More detailed assessment, such as through microsimulation, will be helpful in providing more robust estimates of risk in the populations likely to participate in a BHP and exchange.

3. Potential for Carrier Participation

Currently, Neighborhood Health Plan of RI (NHPRI) and United Healthcare of New England (UHCNE) participate in Rite Care. Blue Cross Blue Shield is the sole carrier in the commercial individual (direct pay) market, but does not currently participate in Rite Care.

As part of the assessment of the BHP opportunity, we met individually with all of the carriers in Rhode Island. Both NHPRI and UHCNE expressed interest in exploring participation in a BHP. A BHP would provide an opportunity for the state to build on the expertise and experience of these carriers in serving Rhode Island's low-income population. Having the same carriers in Rite Care and the BHP also means that enrollees who move back and forth between Medicaid and BHP due to income fluctuations would be able to stay with the same carrier despite these eligibility transitions.

In the absence of a BHP, MMCOs could potentially serve the 133-200% FPL population through the exchange; however, this may be more difficult than through a BHP because of licensing requirements for exchange plans and because exchange plans would need to serve a broader population.

Financial Modeling

This section presents preliminary financial results for a BHP to be implemented in Rhode Island beginning in 2014. It is important to note that the results presented are preliminary because there are uncertainties regarding final regulations and how private insurers and consumers will react to numerous components of healthcare reform that become effective in 2014. The purpose of the analysis is to provide a framework for modeling cash flows under a BHP and to begin the process of estimating the key components that drive those cash flows.

Using publicly available demographic data for Rhode Island, premium information from rate filings, information provided by the state of Rhode Island, and comparative data from other low-income populations, we projected potential CY2014 BHP cash flows under several different scenarios. At the request of the state, we modeled two different potential structures for the BHP: one with all adults between 133-200% FPL in the BHP and one with only parents between 133-200% FPL in the BHP (and childless adults in the exchange). In the results shown below, we also incorporated

estimated avoided costs from extending a Rite Share-like program to the BHP-eligible population, though further clarification will be needed from the federal government as to exactly how and whether a Rite Share-like program could operate in concert with the BHP.

Key assumptions in the model included the following:

- Demographic information obtained from the 2009 American Community Survey and from the state’s “Who goes where” modeling.
- Estimated silver premium in the exchange (used for the calculation of premium and cost sharing subsidies) of \$411 PMPM, based on a separate analysis that we have performed for the state of Rhode Island. We assumed that the state would receive 95% of premium subsidies and 100% of cost-sharing subsidies for the BHP population.
- Estimated expected medical costs in the BHP of \$462 PMPM, based on costs from a similar demographic population adjusted for area cost relativities.⁹ Administrative costs equal to 12% of BHP revenue based on estimates of administrative costs incurred by the state and by health plans in the Rite Care program.
- Member premiums equal to 5% of income or the maximum percent allowed under ACA, where less than 5%. We assumed that BHP members would have no additional cost-sharing.
- A Rite Share-like premium assistance program with “savings” through cost avoidance of \$10 million per year in the baseline model and \$2.8 million per year in the model with only parents in the BHP.

Methods and assumptions are described in more detail in the Appendix.

Results

In the baseline scenario, using assumptions as listed above (and as described in more detail in the Appendix), we estimate that the BHP would result in a surplus of \$6 million per year, based on an overall program cost of \$91 million and expected revenues of \$97 million. This estimate assumes \$10 million in costs avoided from a Rite Share-like program.

Baseline/Neutral Scenario	Annual Revenue (Costs), in Millions
95% of exchange premium subsidies	\$65
100% of cost sharing subsidies	\$22
Total Revenue	\$87
BHP allowed costs	(\$108)
BHP member premium contributions	\$27
BHP member cost-sharing	\$0
BHP administrative costs	(\$10)
Total BHP costs	(\$91)
BHP costs net of estimated potential Rite Share avoided costs	(\$81)
Net surplus (deficit)	\$6

⁹ Independent calculations by Rhode Island staff using the Rhode Island’s Medicaid population cost and Rhode Island population data for the uninsured suggest similar results (\$486 PMPM without a factor for pent-up demand).

In the absence of “savings” through cost avoidance from a Rite Share-like program, the BHP would have a deficit of \$4 million. In this circumstance, the state may wish to evaluate other options for achieving budget neutrality. We calculate that if the state were to introduce member cost-sharing of 0% for those with incomes below 150% FPL, and 10% for those with incomes between 150 and 200% FPL, the BHP (without assuming any Rite Share-like savings) would have a net surplus of \$2 million. We further estimate that approximately 7% cost-sharing for the population between 150 and 200% FPL would achieve budget neutrality, again in the absence of a Rite Share-like program

In order to better understand the factors that drive the results of the model, we further explored our sensitivity of these findings to four major assumptions: estimates of the silver premium, estimates of BHP costs, BHP trend rates, and use of differential cost estimates in the BHP by type of prior coverage. Results were highly sensitive to the first three assumptions but not to the use of differential cost estimates by type of prior coverage.

a. Silver premium

We varied the estimated second lowest silver premium by 10% increments to assess the sensitivity of our results to this variable. We found that results of the model varied substantially with these changes. Uncertainty in the 2nd lowest silver premium is a key risk in the decision whether to pursue a BHP: a 10% change in the premium would significantly impact the financial risk of the program. The estimates shown below incorporate an estimated \$10 million in costs avoided through a Rite Share-like premium assistance program.

Vary Silver Rate	2nd Lowest Silver Plan	BHP Costs	Surplus (Deficit) in millions
Very Favorable	\$493	\$462	\$26.2
Favorable	\$452	\$462	\$16.2
Neutral	\$411	\$462	\$6.2
Unfavorable	\$370	\$462	(\$3.8)
Very Unfavorable	\$329	\$462	(\$13.7)

b. BHP costs

We next varied the estimated costs of the BHP by 10% increments to assess the sensitivity of the results to changes in these costs. Again, results were highly sensitive to changes in these estimates and BHP costs are another major risk in the consideration of the BHP option. Again, these estimates shown below incorporate an estimated \$10 million in costs avoided through a Rite Share-like premium assistance program.

Vary BHP Cost	2 nd Lowest Silver Plan	BHP Costs	Surplus (Deficit) in millions
Very Favorable	\$411	\$370	\$27.8
Favorable	\$411	\$416	\$17.0
Neutral	\$411	\$462	\$6.2
Unfavorable	\$411	\$508	(\$4.6)
Very Unfavorable	\$411	\$554	(\$15.4)

c. Trend rates

Our model assumed a trend rate of 8.5% for the silver plan premium through the Exchange. We assumed a trend of 5.2% for the underlying costs that were used to estimate BHP costs. This is roughly comparable to the state’s estimate of five-year cost trend for children and families in the Rite Care program of 4.5% per year.

We did an additional analysis assuming that BHP costs grew at the same rate as commercial costs, namely 8.5% per year. This results in a composite BHP cost of \$498 PMPM. We show results using this higher trend rate, with a range of estimates for the silver plan premium and the BHP costs. The estimates shown below incorporate an estimated \$10 million in costs avoided from a Rite Share-like premium assistance program.

BHP trend 8.5%, vary Silver rate	2nd Lowest Silver Plan	BHP Costs	Surplus (Deficit) in millions
Very Favorable	\$493	\$498	\$17.7
Favorable	\$452	\$498	\$7.7
Neutral	\$411	\$498	(\$2.3)
Unfavorable	\$370	\$498	(\$12.3)
Very Unfavorable	\$329	\$498	(\$22.2)

BHP trend 8.5%, vary BHP cost	2 nd Lowest Silver Plan	BHP Costs	Surplus (Deficit) in millions
Very Favorable	\$411	\$399	\$11.0
Favorable	\$411	\$449	\$9.4
Neutral	\$411	\$498	(\$2.3)
Unfavorable	\$411	\$548	(\$13.9)
Very Unfavorable	\$411	\$598	(\$25.6)

d. Remove differential costs by coverage type (in estimating BHP costs)

In estimating BHP costs, we assumed that people who were transitioning from different classes of prior coverage (i.e., uninsured, ESI, Medicaid) would have different costs of coverage. This was done to mirror assumptions in an assessment of the BHP in New York state,¹⁰ to reflect concerns about differential health status among people coming into the exchange. To assess the sensitivity of our model to this set of assumptions, we also reran our model without making assumptions about differential costs by previous coverage type (other than the demographic mix inherent in each category). The estimates shown below incorporate an estimated \$10 million in costs avoided from a Rite Share-like premium assistance program. Results did not significantly vary from our baseline results with this change in assumptions.

	2nd Lowest Silver Plan	BHP Costs	Surplus (Deficit) in millions
Baseline	\$411	\$462	\$6.2
Remove differential rates by coverage type in BHP estimate	\$411	\$456	\$7.6

¹⁰ Benjamin ER, Slagle A. Bridging the gap: exploring the basic health insurance option for New York. New York: Community Service Society; 2011.

At the request of the state, we also analyzed how our model would change if only parents between 133-200% FPL were included in the BHP, and childless adults between 133-200% FPL were covered instead through the exchange. The rationale for pursuing this approach includes the desirability of including parents in the BHP because that would allow them to stay in the same plan as their children, and also the potential for decreased financial uncertainty as the state already covers parents up to 175% FPL under Rite Care. Results are shown with a range of estimates for both the silver premium and for the BHP cost. The estimates shown below incorporate an estimated \$2.8 million in costs avoided from a Rite Share-like premium assistance program.

Parents only, vary Silver rate	2nd Lowest Silver Plan	BHP Costs	Surplus (Deficit) in millions
Very Favorable	\$493	\$476	\$12.8
Favorable	\$452	\$476	\$6.1
Neutral	\$411	\$476	(\$0.5)
Unfavorable	\$370	\$476	(\$7.2)
Very Unfavorable	\$329	\$476	(\$13.8)

Parents only, vary BHP cost	2 nd Lowest Silver Plan	BHP Costs	Surplus (Deficit) in millions
Very Favorable	\$411	\$381	\$14.1
Favorable	\$411	\$429	\$6.8
Neutral	\$411	\$476	(\$0.5)
Unfavorable	\$411	\$524	(\$7.8)
Very Unfavorable	\$411	\$571	(\$15.2)

Discussion and Recommendations

This report provides a preliminary assessment of the BHP opportunity for Rhode Island. There are significant uncertainties surrounding BHP implementation, and this analysis reflects current best knowledge, but will need to be updated as additional information becomes available.

For example, there remain a number of key questions that would benefit from clarification from federal regulators, such as:

1. Under the BHP, will the state receive 100% or 95% of cost-sharing subsidies?

Our modeling assumed 100% but the statute appears ambiguous on this point. Were the state to receive only 95%, we estimate the additional cost to be approximately \$1 million in the baseline scenario.

2. Could the state include only parents in BHP, and keep childless adults in the exchange?

It may be particularly appealing to Rhode Island to include parents in a BHP, much like how parents up to 175% FPL are now covered through Rite Care. The parent population, and their associated costs, are already well known, making them a lower risk population to cover through the BHP. In addition, the state may especially want to include parents in a BHP because it would allow families to stay together in Rite Care.

3. Could the state open its Rite Share program to BHP-eligibles?

Continuing Rite Share, or a Rite Share-like program for BHP enrollees, would allow the state to continue to leverage employer contributions to the health insurance premiums of low-income workers and would be financially advantageous to the state. The results shown here assume that the state would be able to operate a Rite Share-like program in which it collects premium tax credits and cost-sharing subsidies for BHP-eligible Rite Share enrollees, and provides subsidies to enrollees to make their employer-sponsored insurance affordable. Being able to operate such a program would make the BHP a less financially risky proposition for the state.

Any assessment of the BHP will need to be updated as answers to these, and other questions, are provided. In addition, better estimates of the demographics of the BHP and exchange populations will also help refine this financial model.

However, based on our preliminary evaluation, we believe that the following are potential advantages to a BHP in Rhode Island:

- Lower out of pocket costs for members
- Enhanced take-up/retention due to keeping parents and children together

We also identify the following risks to the BHP:

- Financial risk to the state. Our initial modeling suggests a modest net surplus to the state, when taking into account estimated potential avoided costs from a RiteShare-like program. This result is driven by the relatively low estimated premium for the exchange and the estimated cost of coverage in the BHP. Changes in either of these factors will change results significantly, and these therefore remain two important high-risk contingencies for the state to continually evaluate in its assessment of the BHP. Introducing modest cost-sharing would help to cushion risk to the state.
- Decreased QHP enrollment through the exchange, though the financial sustainability of the Exchange need not be significantly compromised given the revenue model that the state is currently considering.

As we have modeled it, the state would be taking on non-trivial financial risk (for BHP and the exchange) in return for modest rate relief to select sub-groups within the BHP eligible population, potential increased maintenance of coverage for families, and a significant reduction in cost-sharing (0% in our baseline model). If the state were able to cushion its own risk by adjusting some other variables, such as the degree of cost-sharing, and/or the state were allowed to retain employer contributions under a Rite Share-like program for some of the BHP population, then the case for the BHP would be materially stronger. Further modeling, including microsimulation, would be helpful in getting better estimates of the demographic characteristics of the BHP population. Federal guidance, expected shortly, may also further clarify the risks/benefits of the BHP for Rhode Island.

Appendix: Methods and Assumptions

DEMOGRAPHIC DATA

To build our model, we first developed a data set of all potential enrollees. Rhode Island specific data was obtained from the 2009 American Community Survey and was downloaded from the Integrated Public Use Microdata Series database.¹¹ This initial analysis focused on adults aged 19-64, with incomes between 133-200% FPL. There were 59,000 adults in this category in the raw datafile extracted from the ACS dataset.

Records were then classified by the following categories:

- Age band.
- Gender
- Income band as % of FPL. Income was inflated at an annual rate of 1% to 2014 levels.
- Source of current coverage (Direct Pay/Individual market, Employer Sponsored Insurance, Uninsured, Medicaid). Individuals reporting Medicare, VA, Tricare, or Indian Health Service insurance were not included for further analysis.
- Parent vs. childless adult

We calibrated our take-up rates to match the results of Rhode Island's "who goes where" model. Take-up rates differed by income category and current coverage type. We assumed a "steady-state" for uptake and did not build in ramp-up assumptions.

Of note, legal aliens below 133% FPL who are not yet eligible for Medicaid are also eligible for the BHP. We approximated the number of people who might fall into this category, by calculating the number of adult non-citizens with incomes below 133% FPL who have been in the U.S. for 5 years or less. We estimate that there are approximately 5,900 people in this category. Because of their small number, this group of adults was not included in the current analysis.

The demographic data we used has a number of important limitations. It is also important to note that this demographic data was derived from survey data, which may reflect response bias as well as other data limitations. Income was self-reported, and methods for calculating income and FPL may differ from methods that will be used under the ACA. Finally, though the ACS provides the largest sample size of the nationally available surveys, it may have less reliability at the more granular level required by our analysis.

EXCHANGE PREMIUM CREDITS (REVENUE)

Exchange premium credits are defined as 95% of the second lowest silver premium rate in the state exchange. The second lowest silver rate is an important driver of the results of the BHP model. To obtain estimates of the second lowest silver rate, we started with 2010 data that was supplied to us by Rhode Island carriers, on current plan designs, enrollment, and premiums. Based on this information, we were able to calculate the actuarial values (AVs) of current plans in the

¹¹ Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis: University of Minnesota, 2010.

marketplace. We normalized the premiums to reflect 70% AV and combined the five premiums into a composite rate, weighted by membership. We did this because there was only one plan, with relatively low membership, with an AV close to silver and we did not wish to base our estimates on a single value.

We subsequently applied a calculation of the expected impact of ACA reforms (this calculation and assessment is described in detail in a separate report). We applied a 5% discount to the rate to reflect uncertainties around the essential benefit requirements and procurement specifications for exchange plans. This discount increases the conservatism of our estimations, and would skew toward making the BHP appear less favorable.

Premiums were then trended to 2014 using an annual trend of 8.5%. Premiums were varied by age bands using unisex rate relativities under a 3:1 maximum variance requirement. The baseline premium used for the model took into account the age distribution of the expected BHP population and averaged \$411 PMPM.

Age Band	Silver Rate 2010, with ACA adjustment	Trend Rate	Trended
19-24	\$196.54	8.5%	\$245.97
25-29	\$240.94	8.5%	\$301.53
30-34	\$281.22	8.5%	\$351.94
35-39	\$311.95	8.5%	\$390.41
40-44	\$350.62	8.5%	\$438.80
45-49	\$422.67	8.5%	\$528.98
50-54	\$486.68	8.5%	\$609.09
55-59	\$555.79	8.5%	\$695.58
60-64	\$589.61	8.5%	\$737.90
Total			\$410.79

EXCHANGE COST SHARING SUBSIDY (REVENUE)

The legislative language of the ACA is ambiguous as to whether the BHP would receive 95% or 100% of the federal cost sharing subsidy for its members. We used 100% for our model, and calculated the cost-sharing subsidy as follows:

- Calculation: (2nd Lowest Silver Rate) x (1-Assumed Administrative Rate) x (Subsidy Cost Sharing/0.70 - 1).
- Effective Cost Sharing for Silver Plan: 30%
- Cost Sharing Subsidy: Federal government pays the difference between 30% cost sharing and either 6% for 133%-150% FPL, or 13% for 151%-200% FPL
- Assumed Administrative Rate as Percent of Premium Underlying Silver rate: 20%

ALLOWED MEDICAL COSTS (EXPENSE)

Allowed medical costs means the expected cost for all services covered under the BHP plan before any member cost sharing. In order to estimate allowed medical costs for the Rhode Island BHP, we first estimated the CY2014 expected cost for the entire BHP-eligible population (i.e. all residents with 133%-200% FPL and legal aliens up to 133% FPL). We then developed cost relativities by age/gender and source of current coverage. We were then able to model the impact of different combinations of individuals electing to participate in the BHP.

Allowed medical costs were based on the following steps:

1. We began with CY2010 medical cost data from a comparable program for low income individuals. We used costs from a cohort of individuals with income between 100% and 200% FPL. The program covers a comprehensive set of services that is likely consistent with minimum essential benefits requirement (although details on essential benefits are pending).
2. We trended these costs to CY2014 using a trend rate of 5.2% per year. This rate was derived from analysis performed by Wakely of annual medical expense trend for the comparative population. Separate estimates were also made assuming that cost trends in the BHP were equal to estimated premium trends in the commercial market (8.5% per year).
3. We adjusted net costs to reflect no member cost sharing.
4. We adjusted average unit costs to be consistent with the Medicaid fee schedule in the state.
5. We adjusted expenses to Rhode Island by developing an area adjustment relativity based on Medicaid data. This relativity results in a PMPM cost of \$438.
6. Differential costs were determined for people by category of coverage that they were transitioning from. This was done to mirror assumptions in the NY state report to reflect concerns about differential health status among people coming into the exchange. The model was run both with and without this step.

Coverage	Relativity
Direct	2.58
ESI	0.86
Medicaid	0.95
Uninsured	0.86

7. Projected CY2014 costs for Medicaid parents from 133%-175% were set at \$476 PMPM based on data on current RItE Care costs provided by Rhode Island.
8. Costs for childless adults and other categories of current coverage were recalibrated such that overall cost for population as a whole was \$438 PMPM.
9. Costs used in model were further adjusted for age-gender based on relativities derived from commercial data.

We estimated BHP administrative costs at 12% (including both state and health plan administrative costs), based on data obtained from the state for current estimated administrative costs for RItE Care.

MEMBER COST SHARING (EXPENSE OFFSET)

The state can establish benefit levels with a minimum actuarial value of 90% for individuals with 133%-150% of FPL and 80% of 151%-200% of FPL. Our baseline model assumed no member cost sharing.

MEMBER PREMIUM (EXPENSE OFFSET)

The state can charge BHP enrollees a monthly premium up to the maximum allowed in the Exchange. The maximum is specified as a percent of income and is graded according to income level.

Rite Care members with incomes above 150% FPL pay a premium contribution of approximately 3 % of income. The ACA stipulates that member premium contributions cannot exceed 3% at 133% FPL and 4% at 150% FPL. In our model, we assumed that member premium contributions would be 3-5% of income from 133% to approximately 175% FPL, then 5% of income from 175-200% FPL.

RITE SHARE

Rite Share is Rhode Island's premium assistance program that helps Rite Care-eligible individuals and families afford health insurance through their employer by paying for some or all of the employee's cost. It is not yet clear whether federal regulations will allow Rhode Island to extend the Rite Share model to individuals eligible for the BHP. However, we provide a rough estimation of how much the state could "save" (in avoided costs) if it were allowed to continue a Rite Share-like program for BHP eligibles. This model assumes that members would be covered through employer sponsored insurance (ESI), and that the state would "wrap" the employer benefit by providing premium and cost-sharing subsidies. This model presumes that the state would continue to receive 95% of federal premium tax credits and 100% of cost-sharing subsidies on behalf of these enrollees.

We used the following assumptions in our calculations:

- Number of anticipated BHP enrollees who are transitioning from employer sponsored coverage was derived from the state's "Who goes where" modeling.
- Based on the Rite Share's estimated savings report for 2009, we estimated the total PMPM cost of Rite Share to be \$111 (state payment) + \$8 (member payment), or \$119. This was inflated to 2014 rates using an 8.5% commercial trend. This assumes that the state's contribution would change at the same rate as the overall rise in premiums.
- We assumed that member premium contributions in Rite Share and the BHP would be equivalent.
- We used estimated costs of the BHP in 2014 that were developed for the BHP model (assumptions previously described). These were \$450 PMPM for parents and \$425 PMPM for childless adults. We assumed a BHP administrative cost of 12%. For the purposes of this model, we did not make demographic adjustments to the PMPM estimate.

Results from the "Who Goes Where" model suggest that approximately 2,300 BHP-eligible people could enroll in a Rite Share-like premium assistance program. Based on the assumptions above, the Rite Share costs for this population would be approximately \$3 million per year. In comparison, the BHP costs would be approximately \$13 million per year. The relative savings to the state in these avoided costs is approximately \$10 million annually.

We also modeled a scenario in which only parents are included in the BHP. In this model, approximately 600 BHP-eligible people are estimated to enroll in a Rite Share-like premium

assistance program. The Rite Share costs for this population would be approximately \$860,000, compared with BHP costs of \$3.6 million, resulting in a net savings of \$2.8 million.