Rhode Island State Planning Grant on Access to Health Insurance

HRSA INTERIM REPORT

September 2004

State of Rhode Island
Department of Human Services
600 New London Avenue
Cranston, Rhode Island 02920

Project funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, State Planning Grant #1 P09 OA 01678-01-00

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EXECUTIVE SUMMARY

By letter of September 30, 2003, the State of Rhode Island was awarded a $961,156 Health Resources and Services Administration (HRSA) State Planning Grant (SPG). Governor Donald L. Carcieri designated the Rhode Island Department of Human Services (DHS) the lead agency for project grant activities and Tricia Leddy, Administrator of the DHS Center for Child and Family Health, assumed the role of project director for the grant.

The project has been delayed principally due to major events in Rhode Island's political environment surrounding the regulation of Blue Cross/Blue Shield of Rhode Island (NCBSRI). Specifically, rapidly increasing employer premiums led to widespread dissatisfaction with BCBSRI, the State's largest health insurance carrier with more than 70 percent of the market. The focus on BCBSRI, a not-for-profit entity, led to outrage concerning high executive compensation, BCBSRI Board of Directors compensation, and significant personal loans being given to BCBSRI senior executives. The results have been the resignation of the BCBSRI president, the creation of a Rhode Island Commissioner of Health Insurance with stronger regulatory powers than those vested in the Rhode Island Department of Business Regulation (DBR), and the amendment of BCBSRI's enabling legislation to require that six board members be publicly appointed.

These events led to Governor Carcieri postponing the creation by the Governor of the Health Care Coverage Purchasers Steering Committee that was to be the coordinating point for the HRSA project. Nonetheless, the project was been able to accomplish the following in its first year:

- Establishing contracts with entities to conduct project activities, including Brown University (project coordination and data analysis), John Snow, Inc. (employer survey), HealthCare Analytics (market analysis and quantitative analysis of options), and MCH Evaluation (research synthesis)

- Analyzing *Current Population Survey* and Behavioral Risk Factor Surveillance Survey (BRFSS) data on uninsurance. MCH Evaluation will be performing ongoing analyses as newer data become available.

- Obtaining and initial analysis of Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) data. The Center for Gerontology and Health Care Research at the Brown University School of Medicine will be continuing this analysis as well as conducting employer focus groups.

- Working with the Rhode Island General Assembly in obtaining important direction for policy option consideration. Specifically, DHS has been directed to develop a plan for a pilot primary care program for uninsured residents in the State that may include catastrophic or reinsurance coverage provided under the auspices of the State.

Project activities are proceeding in the following areas:

- **Synthesizing Information and Collecting and Analyzing Data** – Includes quantifying the uninsured, quantifying health insurance coverage, quantifying the health care marketplace, synthesizing State-specific reports, performing secondary data analysis, and collecting and analyzing new data

- **Reviewing and Assessing Approaches/Best Practices** – Includes synthesizing national studies, identifying current approaches/best practices, and inventorying current approaches/best practices

- **Determining and Assessing Option(s) Most Appropriate to the State** – Selecting options that would work for the State, assessing the applicability of current products/programs, determining necessary new/expanded products/programs, and calculating the cost of each option and source of financing

The work will culminate with preparing the Report to the Secretary by the conclusion of the grant period.

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The detailed interim report that follows conforms to HRSA's report format, including all of the questions posed for each ensuing section. If a particular question is not answered, then the State of Rhode Island has not yet undertaken the work necessary to answer the question.

SECTION 1.

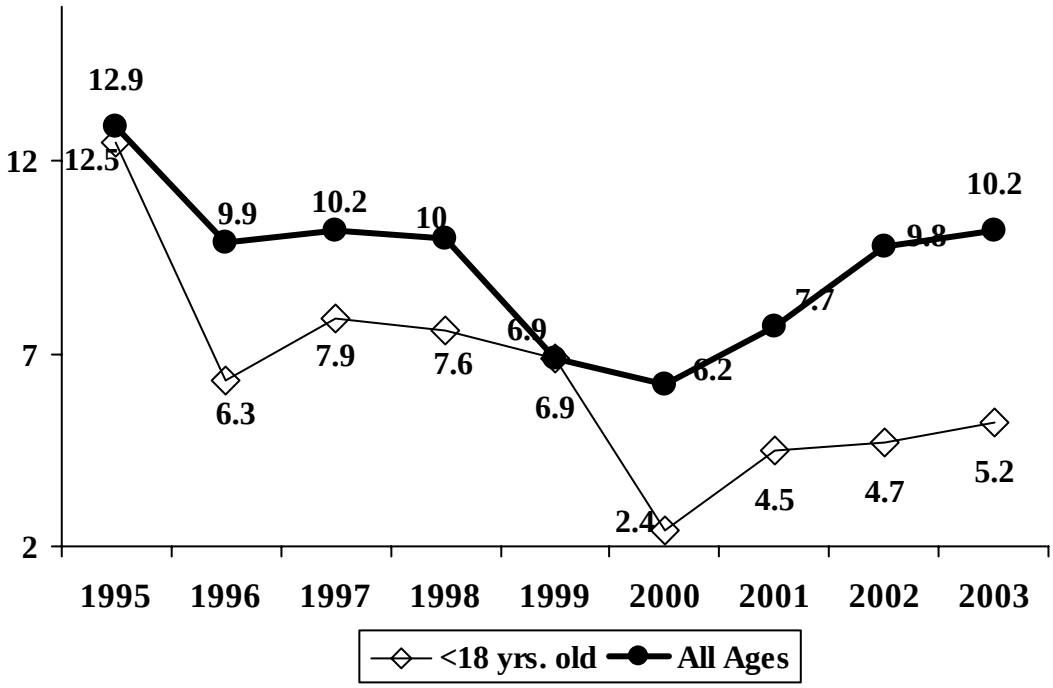
SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

1.1 What is the overall level of uninsurance in Rhode Island?

Based upon data from the most recent *Current Population Surveys* (CPS)1, Figure 1 shows that 10.2 percent of Rhode Islanders of all ages were uninsured in 2003. Rhode Island had[2] the second lowest rate of uninsured in the nation, surpassed only by Vermont with a rate of 9.5 percent. In 2000, Rhode Island had the lowest uninsurance rate[3] in the country for both children and the total population. The figure also shows that after experiencing a sustained, declining trend in the level of uninsurance in the State, in 2001 the level of unisurance increased.

Figure 1

Percent of Uninsured Rhode Islanders by Age Group: 1995 - 2003



[1] U.S. Census Bureau, *Current Population Survey, September 2004*, Table HI06
[2] *Ibid.*
3 Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island, 1995-2002*, RI Medicaid Research and Evaluation Reports. May 2004.

The 2001 – 2003 three-year average[4] showed that Rhode Island had, at 9.3 percent, the second lowest rate of uninsurance in the nation behind Minnesota, at 8.2 percent, which was 38 percent less than the national average of 15.1 percent. The 2002 – 2003 two-year average showed that Rhode Island was tied[5] with Hawaii, New Hampshire, and Vermont, at 10.1 percent, behind Minnesota, at 8.3 percent, which was 34 percent less than the national average of 15.4 percent. Rhode Island was no longer the national leader in the uninsurance rate for children under age 19 at or below 200 percent of the Federal poverty level (FPL)[6], the standard used nationally for the State Children's Health Insurance Program (SCHIP). The data showed the uninsurance rate for low-income children in Rhode Island in 2003 was 3.5 percent – 7th lowest in the nation, behind New Hampshire, Vermont, Maine, Michigan, Hawaii, and Minnesota. Rhode Island's uninsurance rate for low-income children in 2003 was 53 percent less than the national rate of 7.4 percent.

In using CPS data, it is important to keep in mind that the *Current Population Survey* "was not designed as a health insurance survey."[7] While the CPS provides valuable trend information, "comparisons with other surveys have indicated that its estimates for the uninsured tend to be somewhat higher than other major surveys, indicating that underreporting may be a larger problem for the CPS than for some other major surveys that ask questions about insurance coverage."[8] The underreporting for Rhode Island may be considerable. For example, in March 2001 new questions were added to the CPS specifically dealing with SCHIP coverage. Data for Rhode Island showed[9] SCHIP coverage estimates to be 83 percent less than the actual SCHIP coverage in the State (as reported by the State to the Centers for Medicare & Medicaid Services).

The State of Rhode Island has also used Behavioral Risk Factor Surveillance System (BRFSS)[10] data to examine uninsurance in Rhode Island. As Figure 2 shows[11], the percentage of working-age Rhode Islanders who are uninsured increased to 10.8 percent in 2002, after declining from 1996 through 2001.

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[4] U.S. Census Bureau, *Op. Cit.*, Table 9.

[5] *Ibid.*

[6] *Ibid.*, Table HI10.

[7] Nelson, C. T. and R. J. Mills. *The March CPS Health Insurance Verification Question and Its Effect on Estimates of the Uninsured*, U.S. Bureau of the Census, August 2001, 6.

[8] *Ibid.*

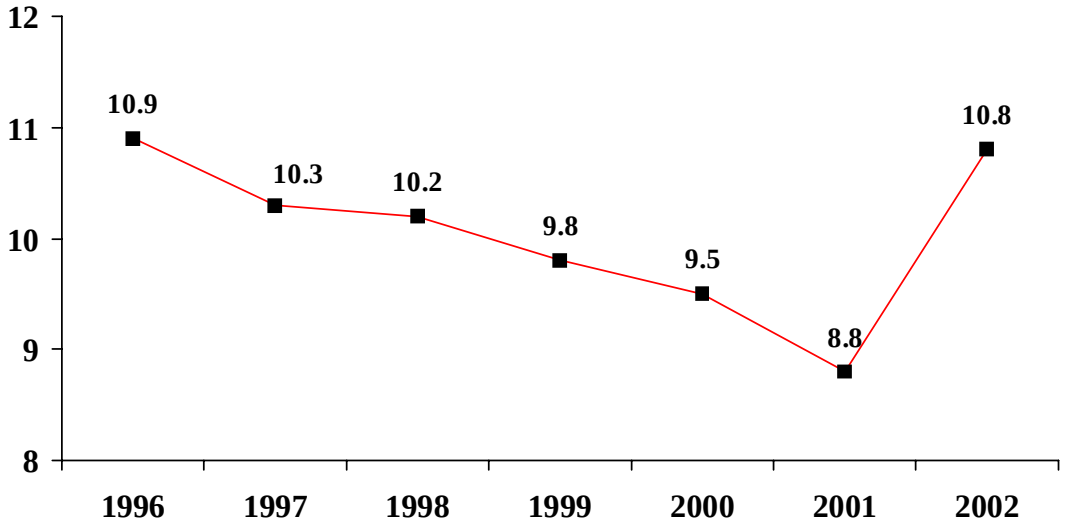
[9] Nelson, C. T. and R. J. Mills. *The Characteristics of Persons Reporting State Children's Health Insurance Program Coverage in the March 2001 Current Population Survey*, U.S. Bureau of the Census, August 2002.

[10] CPS is a random sample of approximately 1,000 Rhode Island households that collects data on type of health insurance for specific age and income groups. BRFSS is a random sample of over 3,500 Rhode Island households that collects demographic, health access measures, as well as employment and income information.

[11] Griffn, J. *Op. Cit.*

Figure 2

Percent Uninsured Rhode Islanders Ages 18-64: 1996-2002



1.2 What are the characteristics of the uninsured?

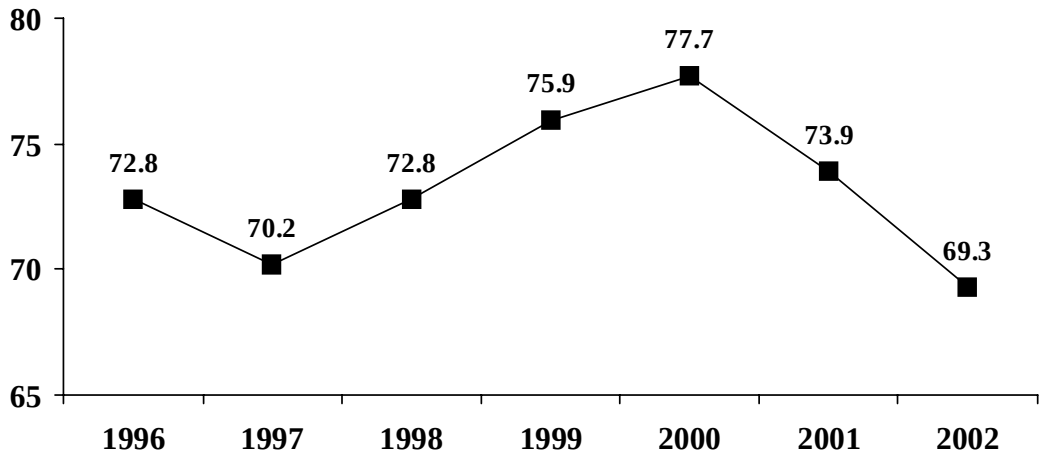
Employer-Based Coverage

Similar to the rest of the country, Rhode Island's decrease in insurance coverage in 2002 was due principally to a decline in employer-based health insurance coverage.[12] Figure 3 below shows that since 2000, the proportion of Rhode Islanders with employer-based health insurance coverage has dropped from 77.7 percent to 69.3 percent. More recent data for 2003 show[13] that employer-based coverage in Rhode Island eroded further – to 65.1 percent in 2003.

[12] U.S. Census Bureau. *Health Insurance Coverage in the United States: 2002*, Report P60-223, 2003.
[13] U.S. Census Bureau. *Current Population Survey, September 2004*, Table .

Figure 3

Percent of Rhode Islanders <65 Years Old with Employer-Based Health Insurance: 1996 - 2002

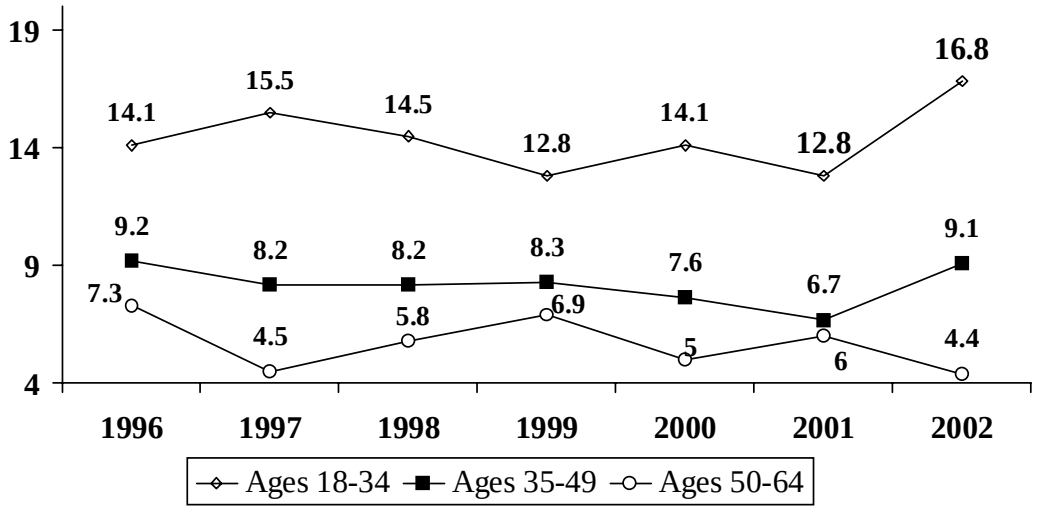


Age

Figure 4 shows that, based on BRFSS data, young working-age Rhode Islanders have the highest rates of uninsured. In 2002, 16.8 percent of Rhode Islanders aged 18 to 34 did not have health insurance. This rate was the highest in seven years and was four times higher than uninsurance among older working-age Rhode Islanders (4.4 percent versus 16.8 percent). After a steady decline in lack of insurance, middle-aged Rhode Islanders aged 35 to 49 saw a significant increase in uninsurance in 2002 from 6.7 percent to 9.1 percent.

Figure 4

Percent Uninsured Rhode Islanders by Age Group Ages 18-64: 1996 - 2002

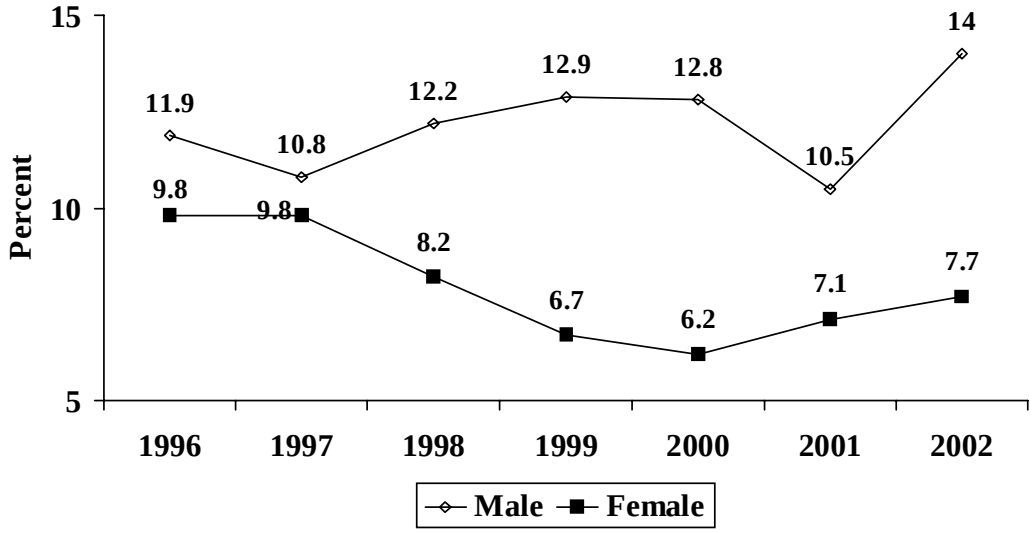


Gender

Based on BRFSS data, Figure 5 shows that, after narrowing the gender gap in 2001, men were once again twice as likely as women to be uninsured in 2002. Men not only saw a significant rise in the proportion of uninsured from 10.5 percent in 2001 to 14 percent in 2002, but also experienced the highest rate of uninsurance ever since 1996. Women also experienced a rise in the proportion of uninsured for the second year in a row.

Figure 5

Percent Uninsured Rhode Islanders by Gender Ages 18-64: 1996 - 2002

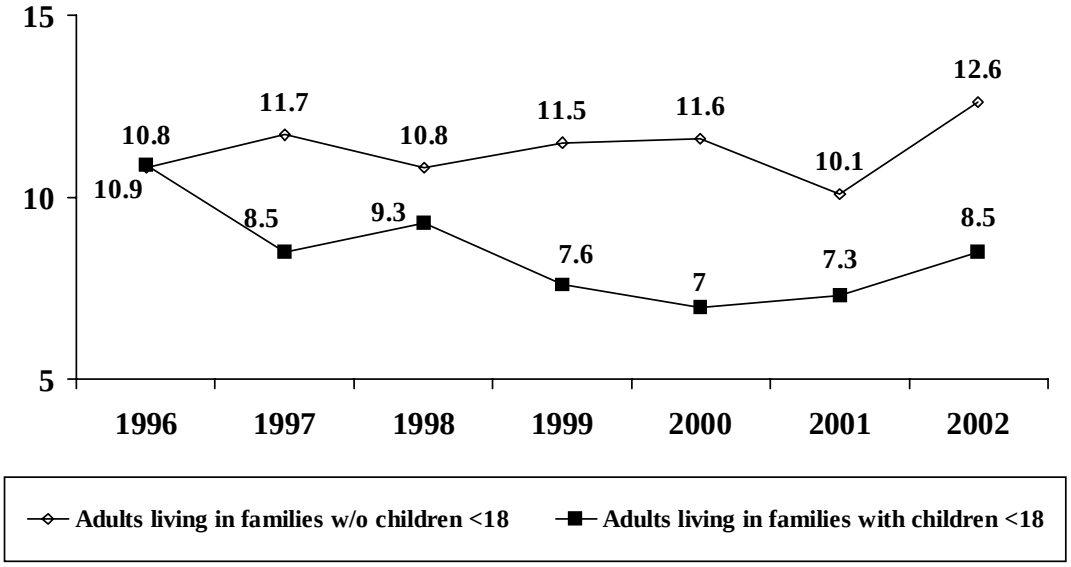


Family Composition

Based on BRFSS data, Figure 6 shows that the rate of uninsurance in households without children rose 25 percent from 10.1 percent in 2001 to 12.6 percent in 2002. In families with children, the proportion of uninsured with children, the proportion of uninsured increased from 7.3 percent to 8.5 percent. The number of uninsured Rhode Islanders increased in both households with and without children.

Figure 6

Percent Uninsured Rhode Islanders by Family Composition Ages 18-64: 1996 - 2002

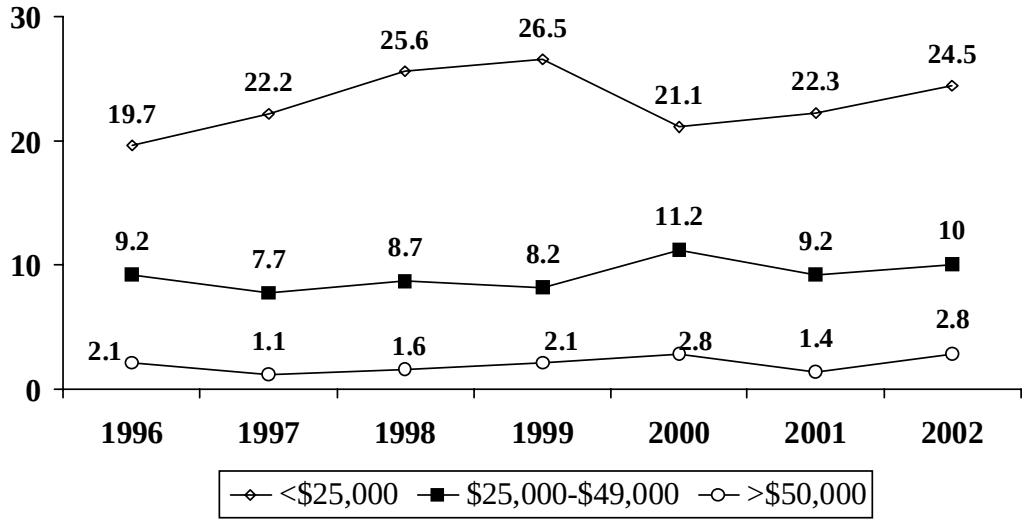


Income

Based on BRFSS data, Figure 7 shows that uninsurance rates rose slightly across all income groups. Low income Rhode Islanders continue to have the highest proportion of uninsured. One in four low-income, working-age Rhode Islanders are uninsured. Members of Rhode Island households with income less than $25,000 are 2.5 times more likely to be uninsured than middle income households with incomes between $25,000 and $50,000.

Figure 7

Percent Uninsured Rhode Islanders by Income Level Ages 18-64: 1996 - 2002

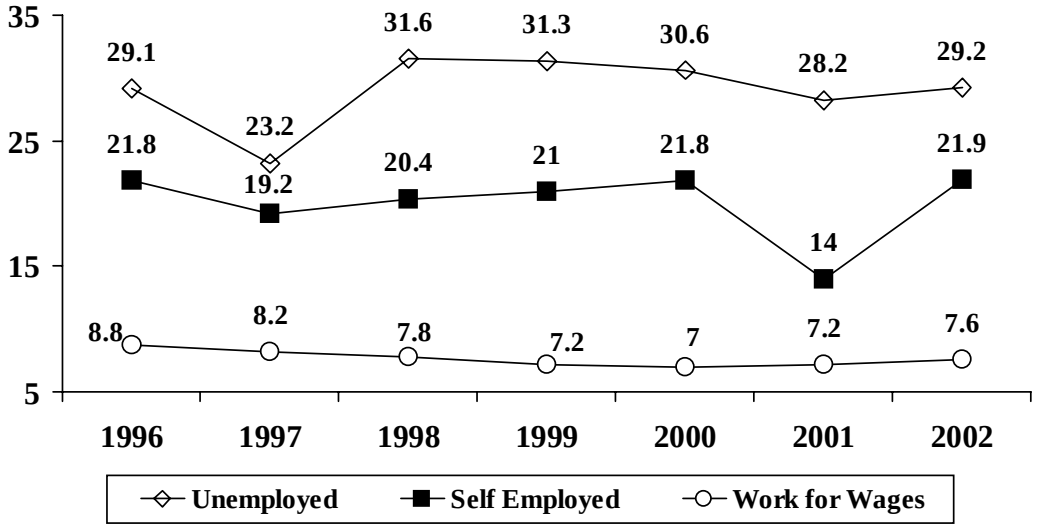


Employment

Unemployment is the single characteristic most associated with being uninsured. Twenty-nine percent of unemployed Rhode Islanders were uninsured. Based on BRFSS data, Figure 8 shows that unemployed Rhode Islanders were over four times more likely in 2002 to be uninsured than Rhode Islanders who work for wages. Only 7.6 percent of Rhode Islanders who work for wages were uninsured. Self employed individuals also had a high proportion of uninsured; 22 percent of Rhode Islanders who were self employed lack health insurance.

Figure 8

Percent Uninsured Rhode Islanders by Employment Status Ages 18-64: 1996 - 2002



1.3 Summarizing the information provided above, what population groupings were particularly important for Rhode Island in developing targeted coverage expansion options?

1.4 What is affordable coverage? How much are the uninsured willing to pay?

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

1.6 Why do uninsured individuals and families disenroll from public programs?

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

1.9 How are individuals to be influenced by:

Availability of subsidies?

Tax credits or other incentives?

1.10 What other barriers besides affordability prevent the purchase of health insurance?

1.11 How are the uninsured getting their medical needs met?

Like other States, access to care is affected adversely for the uninsured in Rhode Island[14]:

- The uninsured are less likely to have a usual source of care outside of an emergency room.[15]
- The uninsured go without screenings and preventive care.
- The uninsured often delay or forgo needed medical care.
- The uninsured are often subject to avoidable hospital stays.
- The uninsured are sicker and die earlier than those who have insurance.
- Medical care is more costly for the uninsured than for the insured.

Unique to Rhode Island is an issue of lead poisoning, because of the age of the State's housing stock. In a study[16], 79.8 percent of children aged 19 to 35 months who had been continuously enrolled in RIte Care for at least one year had a documented blood lead screen test. Minority children, children in homes with other than English spoken in the home, and children living in the "core city" all had statistically significant higher

[14] Families USA. *Going Without Health Insurance: Nearly One in Three Non-Elderly Americans*, The Robert Wood Johnson Foundation, March 2003.

[15] Even for the Medicaid population in Rhode Island, prior to implementing its managed care program, RIte Care, approximately 50 percent of inner residents used hospital emergency departments for preventive care.

[16] Vivier, P.M., *et.al.* "A Statewide Assessment of Lead Screening Histories of Preschool Children Managed in a Medicaid Managed care Program," *Pediatrics*, 108(2), 2001.

screening levels. These are important results given the risk factors associated with lead poisoning.

These screening rates were dramatically higher than those published in national surveys.[17] Uninsured children have lower screening levels, which is important given the screenings found that children enrolled in RIte Care had a higher percentage (at 29.4 percent) with elevated blood lead levels (>10 mg/dl) on at least one test, when compared to national data[18] (at 8.6 percent).

The State of Rhode Island recognizes the importance of lead screening in order to identify lead poisoning and intervene early. It is also important to recognize in this regard that the Department of Human Services (DHS) supports a Comprehensive Lead Center Program that includes window replacement as a RIte Care-covered benefit.

Cultural and language issues also pose some access concerns. Fifteen percent of Rhode Island's population in the 2000 Census was non-White (5.0 percent other race, 4.5 percent Black/African American, 2,6 percent "two+" races, 2.3 percent Asian or Pacific Islander, 0.5 percent American Indian/Alaskan Native) and another 9 percent of the population considered themselves Hispanic.[19] As of March 31, 2003, 26,232, or 22.1 percent of RIte Care enrollees spoke other than English as they primary language at home.[20] DHS has recognized this and has required RIte Care-participating Health Plans to translate member materials into multiple languages to ensure members understand how to access services. Materials have bee translated into Spanish, Portuguese, Cambodian, Laotian, Vietnamese, Hmong, French, and Russian.

Teenage pregnancy ("teen births") is also an important concern, and has been the subject of separate study.[21] The study showed that Rhode Island had the highest rate of teen births in New England, and that the teen birth rate was higher among Medicaid recipients than privately insured teens. The following illustrates the latter point:

- One in 10 births in Rhode Island is to a teenager
- Medicaid pays for 2 out of 3 teen births
- One in 5 Medicaid births is to teens compared to one in 20 privately insured births

[17] Kaufmann, R. B., *et.al.*, "Elevated Blood Lead Levels and Blood Lead Screening among US Children Aged One to Five Years: 1988 – 1994," *Pediatrics*, 106(6), 2000.

[18] *Ibid.*

[19] U.S. Census Bureau. *Table DP-1. Profile of General Demographic Characteristic: 2000*.

[20] Rhode Island Department of Human Services. *RIte Care/RIte Share Quarterly Report: January to March 2003*.

[21] Griffin, J. *Teen Births in Rhode Island: A Needs Assessment*, Medicaid Research and Evaluation Project, March 2002. See, also: Griffin, J. *The Effect of RIte Care on Teen Births in Rhode Island: 1993 –1999*, Medicaid Research and Evaluation Project, December 2001.

If not for RIte Care, many of these teen mothers would not have been insured. The studied highlighted the following risk factors as contributing differentially, when compared to the other New England States, to the teen birth rate in Rhode Island:

- Rhode Island has the highest poverty rate in New England
- Rhode Island has the highest rate of high school dropouts and teens not working in New England
- Rhode Island has more barriers to family planning services than other New England States

1.12 What are the features of an adequate, barebones benefit package?

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

SECTION 2.

SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

In 1999, the Rhode Island Department of Health undertook a survey of employer health insurance coverage. For employed adults, the employer's size bears on whether employees are offered health benefits. Table 1 shows that the larger the employer, the more likely health benefits are offered to some or all employees.

Table 1

Percentage of Employers Who Offer Health Benefits to Some or All Employees by Employer Size

Employer Size	Rhode Island	United States
3 – 9 employees	68%	55%
10 – 24 employees	89%	72%
25 – 49 employees	93%	86%
50 – 199 employees	97%	92%
200+ employees	100%	99%

Making health benefits available does not, however, mean that they are available to everyone. In Rhode Island in firms where health coverage was offered, 77 percent of employees were eligible to enroll and 23 percent were not. Restrictions on eligibility often had to do with full- versus part-time employment (or number of hours worked), as Table 2 shows. Full-time employees are more likely to be offered coverage than part-time employees, irrespective of employer type or the number of employees.

Table 2

Eligibility for Health Coverage Among Rhode Island Employers Who Offer

Type of Organization/Number of Employees	Percent of Full-Time Employees Eligible for Coverage	Percent of Part-Time Employees Eligible for Coverage
Private		
3 – 9 employees	89.5%	28.4%
10 – 49 employees	90.5%	27.8%
25 – 49 employees	88.3%	19.4%
50 – 99 employees	90.1%	25.5%
100+ employees	93.0%	38.8%
Government (3+ employees)	96.7%	30.5%
All employers	**91.6%**	**32.5%**

Seventy-four percent of employers who offered health coverage also restricted eligibility through waiting periods for new employees and for previously unenrolled employees, and for 60 percent of these employers the waiting period was 30 days or more.

The offer of coverage does not necessarily translate to enrollment. Overall, only 75 percent of eligible employees elected to do so, with greater enrollment among full- rather than part-time employees (80 percent versus 36 percent) and among government rather than private employees (94 percent versus 75 percent). Most employers offered their employees with families the option of family coverage, in addition coverage for the employee, and 54 percent of full-time employees who were enrolled had family coverage as did 49 percent of part-time employees.

The employer survey is being repeated as one of the activities under this HRSA grant. In the State's final project report, results for 2004 will be compared to the earlier study.

2.2 What influence the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit packages, and other features of the coverage?

2.4 What would be the likely response of employers to an economic downturn or continued increases in cost?

2.5 What employer and employee groups are most susceptible to crowd-out?

2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?

Individuals or employer subsidies?

Additional tax incentives?

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

SECTION 3.

SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did Rhode Island define adequate?

3.2 What is the variation in benefits among non-group, small group, large group, and self-insured plans?

3.3 How prevalent are self-insured firms in Rhode Island?

3.4 What impact does Rhode Island have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

As Table 3 shows[22], there were 779,223 covered lives in Rhode Island-based health insurance companies as of December 31, 2001, almost unchanged from the year before but down nine percent from 1999. While Neighborhood Health Plan of Rhode Island (NHPRI)[23] had the least membership, it had the largest percentage membership increase from the year before. Membership in Blue Cross and Blue Shield of Rhode Island (BCBSRI) increased by 19 percent and BlueCHiP's (also owned by BCNSRI) membership increased 27 percent from the previous. United Healthcare of New England's (UHCNE's) membership decreased by 24 percent.

[22] Governor's Advisory Council on Health. *Annual Report 2002*, State of Rhode Island, Chart 20. The Governor's Advisory Council on Health provides quantitative information about the major components of the health care industry in Rhode Island.

[23] NHPRI was created in 1994 by Rhode Island's community health centers to participate in the State's Medicaid managed care program, RIte Care.

Table 3

Rhode Island Health Plan Enrollment by Insurer, 1999-2001

Health Plan	1999	2000	2002
BCBSRI	352,724	391,889	419,474
UHCNE	221,868	209,896	168,317
HPHC	153,558	0	0
BlueCHiP	92,147	115,566	116,829
NHPRI	35,985	62,937	74,603
Total	**856,282**	**780,288**	**779,223**

The sudden departure of Harvard Pilgrim Health Care (HPHC) from the Rhode Island market in 1999 resulted in a change in health insurance coverage for over 150,000 people. Some of the members enrolled in other Rhode Island-based health insurance plans. Many were residents of Massachusetts and shifted their enrollment to HPHC's Massachusetts-based plan, or to other Massachusetts-based insurers, resulting in a decrease to the total number of covered lives by Rhode Island insurers.

Table 3 also shows the very large market concentration of BCBSRI, representing 69 percent of the market when BlueCHiP's enrollment is included. This market concentration is greater than in prior studies[24], where Rhode Island ranked only behind Alabama, Idaho, and North Dakota in market domination by the State's largest insurer.

Table 4 shows Rhode Island enrollment by type of health insurance product.[25] At the end of 2001, 45 percent of covered lives were insured by an *indemnity* plan – a large increase from the 35 percent in 1999. During this period, the proportion of covered lives enrolled in a commercial health maintenance organization (HMO)[26] product decreased from 33 to 19 percent, while the proportion enrolled in an HMO Medicaid product increased from 9 to 12 percent. The proportion of total covered lives in Medicare and Medicaid fee-for-service (FFS) as well as in an HMO Medicare product generally remained the same.

[24] See, for example: Chollet, D.J., A.E. Kirk, and M.E. Chow. *Mapping State Health Insurance Markets: Structure and Change in the State's Group and Individual Health Insurance Markets 1995-1997*, Academy for Health Services Policy and Research, December 2000.

[25] Governor's Advisory Council on Health. *Op.Cit.*, Chart 22.

[26] All three HMOs participating in RIte Care have full, three-year accreditation from NCQA. Coordinated Health Partners (CHP, or Blue ChiP) received an "excellent" designation from NCQA. Neighborhood Health Plan of Rhode Island (NHPRI), a Medicaid-only HMO, also has an "excellent" designation; in fact, NHPRI is designated "excellent" in all categories by NCQA – access and service, qualified providers, staying healthy, getting better, living with illness, and accreditation outcome. Both CHP and United HealthCare of New England (UHCNE) have their Medicaid product lines accredited by NCQA and both are Medicare+Choice participating plans.

Table 4

Percentage Enrollment by Type of Coverage in Rhode Island, 1999-2001

Type of Coverage	1999	2000	2001
Indemnity	35%	42%	45%
Commercial HMO	33%	23%	19%
Medicare FFS	12%	13%	13%
Medicaid HMO	9%	11%	12%
Medicare HMO	6%	6%	6%
Medicaid FFS	5%	5%	5%

As of December 31, 2001**,** 69 percent of the Medicaid (compared to 58 percent nationally) and 33 percent of the Medicare (compared to 14 percent nationally) populations were enrolled in managed care.[27]

These market analyses are being updated and will be included in the State's final project report. An important marketplace factor to be highlighted will be BCBSRI's decision to surrender its State HMO license, as part of the organization's repositioning strategy for the future.

3.6 How would universal coverage affect the financial status of health plans and providers?

3.7 How did the planning process take safety net providers into account?

Rhode Island does not have health departments as units of local government. Thus, the State's community health centers serve as the safety net for the uninsured in 22 locations throughout the State. The State's 14 hospitals (particularly the emergency departments and clinics) also serve a safety net function, with cost-adjusted charity care as a percentage of net patient revenue at one percent in 2000.

3.8 How would utilization change under universal coverage?

3.9 Did Rhode Island consider the experience of other State with regard to:

Expansions of public coverage?

Public/private partnerships?

[27] Governor's Advisory Council on Health. *Op. Cit.*, Charts 23 and 24.

Incentives for employers to offer coverage?

Regulation of the marketplace?

SECTION 4.

OPTIONS AND PROGRESS IN EXPANDING COVERAGE

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1932, employer buy-in programs, tax credits for employers or individuals, etc.)?

The State's consideration of options is rooted in its history of coverage expansions. The State of Rhode Island has approached uninsurance in the population incrementally. In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1)[28] by the U.S. Department of Health and Human Services (HHS) to develop and implement a mandatory Medicaid managed care demonstration program called RIte Care. RIte Care, implemented in August 1994, has the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

The pursuit of this waiver flowed from enactment in 1993 of § 42-12.3 of the General Laws (G.L.) of Rhode Island. The intent of the Rhode Island General Assembly was explicit, as shown in §42-12.3-2:

> "It is the intent of the general assembly to assure access to the comprehensive health care by providing health insurance to all Rhode Islanders who are uninsured."

Thus, for more than a decade Rhode Island has pursued this intent.

RIte Care was designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)[29] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)

[28] The waiver runs through July 31, 2005.

[29]Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF). FIP is Rhode Island's program for the TANF-eligible population.

- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

RIte Care has been expanded six times, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured

- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured

- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185 of the FPL (expansion under Section 1931 of the Social Security Act)

- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL

- Effective December 1, 2000, to maximize children in foster care placements from fee-for-service Medicaid to RIte Care

- Effective January 29, 2003, to enroll children with special health care needs into RIte Care including:

    - Blind/disabled children and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)

    - Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children)

    - Children receiving subsidized adoption assistance

The May 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI (State Children's Health Insurance Program, or SCHIP) of the Social Security Act.[30] By Section 1115 SCHIP waiver approval (21-W-00002/1-01)[31], effective January 18, 2001, Section 1931 parents and relative caretakers and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. On April 17, 2003, Rhode Island became the first State to be approved by CMS for a separate child health program under SCHIP to cover unborn children with family income up to 250 percent of the FPL. This allows the State to provide coverage for pregnant women who are not eligible for Medicaid due to their "unqualified" alien status.

[30] The State did obtain approval on January 5, 1999 to expand SCHIP coverage for children aged 8 to 19 up to 300 percent of the FPL, but this expansion has not been undertaken to due budget constraints.
[31] The waiver runs through January 17, 2006.

In addition to these covered populations, the RIte Care Health Plans must make coverage available to certain State-funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL

- Children who are uninsured whose household income is in excess of 250 percent of the FPL

- Licensed family child care providers and their children under age 18

RIte Care has been demonstrably successful in accomplishing its goals – at times, perhaps, too successful. RIte Care's enrollment grew substantially from 1998 through 2001 as a result of four significant and concurrent events:

- As noted above, the State expanded eligibility to parents and relative caretakers of RIte Care-enrolled children up to 185 percent of the FPL, under Section 1931 of the Social Security Act.

- The State streamlined the RIte Care application process, by creating a short, mail-in application in English and Spanish and eliminating face-to-face interviews for both the initial eligibility determination and for re-determination.

- The State embarked on an ambitious community-based outreach campaign to reach and enroll uninsured children and families.

- The State's commercial insurance market began to deteriorate, marked by sharp increases in premium rates offered to employers, reduced competition as a result of two of the State's commercial insurers (i.e., Harvard Pilgrim and Tufts), and significant hospital and Health Plan losses.

Over the same period of time, RIte Care's enrollment grew by 41 percent – from 74,000 in November 1998 to 104,000 by June 2000. Before that time, RIte Care enrollment had remained relatively stable despite the incremental expansions in coverage for children described earlier. The magnitude of the enrollment growth caused large, unexpected increases in program costs.

While it is still unclear to the State which of these four events contributed most to RIte Care's enrollment growth, it was most likely the combination of all four. It is also unclear how much of RIte Care's growth was due to a shift from private, employer-sponsored insurance (ESI) coverage to public coverage (referred to in the research

literature as either "substitution" or "crowd-out"), although to some degree this undoubtedly occurred.

In January 2000, then Governor Lincoln Almond convened a group of Administration staff, legislative leaders, and consumer and business representatives to find a solution to Rhode Island's deteriorating health insurance market. The Health Care Steering Committee (Steering Committee), as the workgroup was called, was jointly chaired by: Christine Ferguson, then Director of the Rhode Island Department of Human Services (DHS); Senator Thomas Izzo, Chair of the Senate Health, Education and Welfare Committee; and Representative Gerard Martineau, House Majority Leader. The Steering Committee was broadly representative of employers, consumers, labor, and the legislative and executive branches of government. Health care providers and insurers were invited to attend meetings and provide testimony to the Steering Committee.

During the next six months, the Steering Committee focused on methods to stabilize the ESI market. Specifically, the Steering Committee examined methods to enable small businesses to maintain ESI by stabilizing premium rates and by assisting and encouraging low-wage workers to maintain ESI. The focus on small employers was due to the increasing number of businesses with less than 50 workers reporting the most volatile rate increases and the resulting difficulty in retaining and/or obtaining ESI, as well as the vital role these employers play in the State's overall economic health.

Governor Almond signed the resulting consensus legislative proposal into law on July 1, 2000. The legislation, Health Reform Rhode Island 2000, included the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

- **Part 1 –** Directing DHS to stabilize the RIte Care program by targeting resources to those most in need of coverage–low-wage families without access to affordable coverage, through:

  - Authorizing DHS to establish eligibility requirements for RIte Care to deter substitution (i.e., a waiting period for new applicants who were enrolled in ESI within six months prior to application)

  - Establishing cost-sharing requirements for certain RIte Care-eligible populations to promote both responsible utilization of health care services and development of additional disincentives for substitution

  - Requiring mandatory participation in RIte Share of eligible individuals and families who have access to ESI. RIte Share[32] is the premium

[32] Under RIte Share individuals with access to ESI, irrespective of their being otherwise eligible for

assistance program created by the statute to support employees in purchasing or retaining ESI. (This was been implemented under a separate Section 1906 Medicaid State Plan Amendment.)

- **Part 2 –** Reforming the health insurance marketplace to conform with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, stabilize premiums in the small group market by compressing rate bands, and guarantee issue of a basic health plan

- **Part 3 –** Establishing new financial reserve requirements for health insurance, consistent with the recommendations of the National Association of Insurance Commissioners (NAIC)

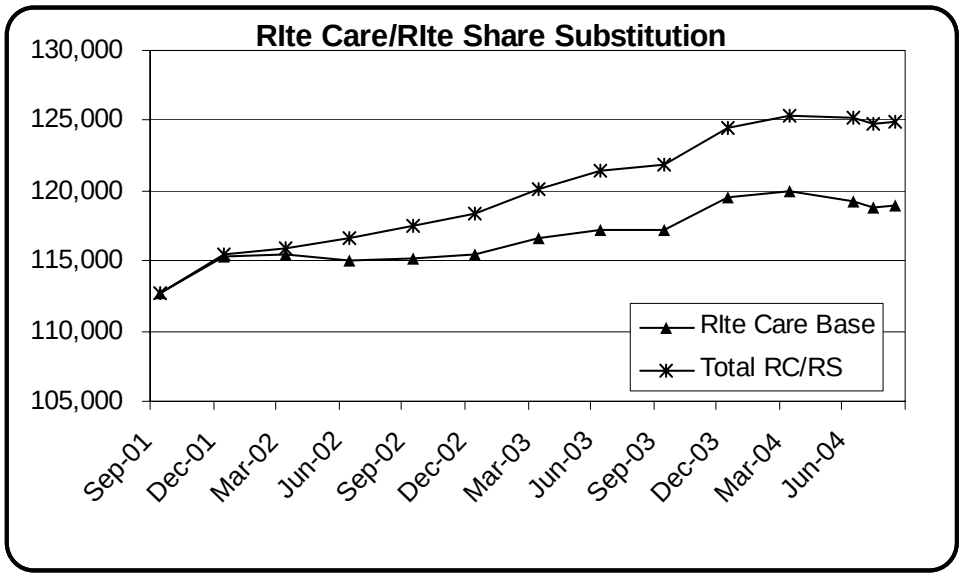
The passage of Part 1 of the Health Reform Rhode Island 2000 represented a significant and important consensus among the Governor and leaders in the General Assembly – RIte Care must be consistent with its original mission to provide coverage to the truly uninsured and migration from ESI to RIte Care should be deterred. The Governor and General Assembly were also clear that if the RIte Care caseload and cost growth are not controlled by Part 1 of the statute, a roll-back of eligibility expansions currently in place for working families, particularly the Section 1931 expansion implemented in 1998 for parents and relative caretakers whose incomes are above TANF levels, will be considered.

There is no doubt that the reduction in the level of uninsurance shown in Figure 1 was due to RIte Care. As Figure 9 shows, enrollment in RIte Care and, now, RIte Share continue to grow, reached 123,525 as of August 31, 2004.

Medicaid, must enroll in the employer-sponsored plan. The State and the family share in the cost of the premium (the family's share is set so as not to exceed 5 percent of family income). RIte Share also covers the costs of co-payments and provides Medicaid-covered services not covered by ESI as wraparound benefits.

Figure 9

RIte Care/RIte Share Enrollment Update as of August 31, 2004 *



	RIte Care Base	RIte Share Current	Total RC/RS
Qtr ending S-01	112,733	40	112,773
Qtr ending D-01	115,286	111	115,397
Qtr ending M-02	115,508	409	115,917
Qtr ending J-02	115,041	1,596	116,637
Qtr ending S-02	115,237	2,304	117,541
Qtr ending D-02	115,526	2,905	118,431
Qtr ending M-03	116,640	3,511	120,151
Qtr ending J-03	117,218	4,268	121,486
Qtr ending S-03	117,154	4,701	121,855
Qtr ending D-03	119,479	5,006	124,485
Qtr ending M-04	119,986	5,432	125,418
Qtr ending J-04	119,279	5,899	125,178
July-04	118,779	5,982	124,761
August-04	119,008	5,880	124,888
Net Change This Month	**229**	**(102)**	**127**

Enrollment of both employees and employers in the RIte Share program has continued to grow. As of January 2002, 117 employers were approved for participation in RIte Share. As of December 31, 2003, 969 employers were approved for participation in RIte Share.

Since February 2001, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition a RIte Care member to RIte Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large rate increases through the magnitude of deductibles. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent. Thus, while plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and employees) particularly in a "down economy".

Part 1 of Health Reform Rhode Island 2000 seems to be accomplishing its intended results. In RIte Care, DHS pays Health Plans $450 per month for an average RIte Care family. RIte Share's average monthly contribution to a family's ESI coverage is $338 (approximately one-half of the monthly cost of family coverage in the Rhode Island commercial health insurance market). Through the end of December 31, 2003, RIte Share has saved $6,106,493 since the program began in 2001, as Table 4 shows[33]. RIte Share ensures that Medicaid is the insurer of last resort and enables DHS to leverage commercial insurance to offset State dollars.

[33] Morrison, L. *Estimated Savings from the RIte Share Program*, Rhode Island Department of Human Services, August 2004.

Table 4

RIte Share Gross and Net Savings

	SFY 2002	SFY2003	SFY 2004*
RITE CARE EXPENDITUTRES AVOIDED			
(1) RIte Care Capitations	$814,569	$5,694,085	$4,474,486
(2) Risk Share	40,275	307,883	364,475
(3) Stop-Loss	5.643	22,501	17,495
(4) CHC Transition Payments	20,113	150,004	116,632
(5) Subtotal (1+2+3+4)	880,601	6,174,472	4,973,088
(6) Cost-Shares Paid	-0-	200,091	149,333
Total RIte Care Expenditures Avoided (5-6)	**$880,601**	**$5,974,381**	**$4,823,755**
RITE SHARE EXPENDITURES			
(1) Premium Subsidies	$406,600	$2,367,055	$2,039,378
(2) Supplementary Benefits	31,201	666,103	61,906
Total RIte Share Expenditures	**$437,801**	**$3,033,158**	**$2,101,284**
RITE SHARE SAVINGS			
(1) Gross Federal-Level Savings	$271,822	$1,861,337	$1,771.440
(2) Gross State-Level Savings	170,979	1,079,885	951,031
(3) Gross RIte Share Savings (1+2)	**$442,881**	**$2,941,222**	**$2,722,471**

To discourage *crowd-out* (i.e., substituting public coverage for ESI), the State is using a combination of cost-sharing and mandatory enrollment in RIte Share. Since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of their health insurance coverage if their income is above 150 percent of the FPL (e.g., $22,530 for a family of three). In November 2001 families received two letters and an official notice about the change. The first monthly bills were sent in December 2001, requiring payment by January 1, 2002. Rhode Island was one of four States increasing enrollee cost-sharing in 2002, with another 11 States expected to do so in 2003[34].

[34] Academy Health. *State of the State: Bridging the Health Coverage Gap*, January 2003.

Monthly premium shares are collected in two ways:

- For RIte Care members, DHS sends a bill and the family pays DHS directly by mailing a check.

- For RIte Share members, DHS deducts the monthly premium share from the amount it reimburses the member for the employee's share of employer coverage.

The monthly family share amount by income level is shown in Table 5[35], comparing the original premium-share amounts to those in effect since August 1, 2002. These premium-share increases were a result of a State law mandating that cost-sharing be raised.

Table 5

RIte Care and RIte Share Monthly Family Premiums

Income Level	Monthly Family Premium From 1/1/02 to 7/31/02	Monthly Family Premium As Of 8/1/02
150%-185% of FPL	$43	$61
185%-200% of FPL	$53	$77
200%-250% of FPL	$58	$92

On a monthly basis, about 10 percent of all RIte Care/RIte Share families are subject to cost-sharing. Table 6 shows the number of families and individuals, by income level, active in cost-sharing as of December 31, 2003. There were 4,628 RIte Care/RIte Share families 12,237 individuals) active in cost-sharing at the end of December 2003. There were 13,431 RIte Care/RIte Share families *ever* active in cost-sharing through December 2003.

[35] Rhode Island law limits monthly premium payments to no more than five percent of a family's income. Prior to January 1, 2002, enrollees with incomes above 185 percent of the FPL had a choice of paying a portion of their premium each month along with a short schedule of co-payments or paying no premiums and being subject to a longer schedule of co-payments.

Table 6

RIte Care/ RIte Share Families and Individuals Active in Cost-Sharing as of December 31, 2003

Income Level	Families	Adults	Children	Total Individuals
150-185% of FPL	2,969	3,878	5,300	9,178
185-200% of FPL	580	105	964	1,069
200-250% of FPL	1,079	181	1,809	1,990
Total	**4,628**	**4,164**	**8,073**	**12,237**

Part 2 of Health Reform Rhode Island 2000, small group reform, has not gone as smoothly as RIte Share and premium collection portions of the statute. A study[36] of market conduct examinations of the effectiveness of Part 2 of the statute showed:

- The major Rhode Island carriers – BCBSRI, BlueChiP, and UHCNE – provided virtually all the small employer health plans in the State.

- All three carriers delayed renewing a significant portion of their small employer groups to avoid compliance with the statute until October or November 2001. The small employer groups most affected by this were the smallest of the small employers.

- Important provisions of the statute were either not implemented or implemented incorrectly by the carriers, which affected all of the small employer groups.

An example of the latter point was the rating portions of the statute. The statute had two phases of implementation in increasing a carrier's premium rating requirements, in order to mitigate the impact on employers and employees. The first phase began October 1,

[36] Lautzenheiser & Associates. *Report on the Effectiveness of Rhode Island General Laws §§ 27-50-1 et seq. Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability*, June 30, 2002.

2000. It included requirements to limit the spread of rates to a range of four-to-one from highest to lowest (i.e., 4-1 rate compression) and to limit rate adjustments for health status to ± 10 percent from the adjusted community rate. The second phase was scheduled to begin July 13, 2002, but was delayed by the Rhode Island General Assembly until October 1, 2004. The second phase is to limit the spread of rates to 2-1 compression and eliminate the use of health status in rating.

While long in its historical description, it was important in underscoring that Rhode Island has already implemented what many other States are just now contemplating.

The Rhode Island General Assembly has, however, directed DHS to examine other options as well to address the ongoing uninsurance in the State. G.L. 40-8.4, which incorporates the Health Reform Rhode Island 2000 initiatives, also directed DHS, in § 40-8.4-7, to:

> ". . . investigate and develop opportunities for individuals and/or employers to buy into, at the individual's and or employer's expense, one or more programs the department may establish under this chapter or chapter 12.3 of title 42 to address uninsurance among Rhode Islanders . . ."

In addition, the recently enacted H 7713 requires DHS to:

> ". . . develop a plan for a primary care pilot program for iuninsured residents in the state. This program may include enrollee premiums and co-insurance payments that are income-based with premiums and co-insurance subsidized by the state. The pilot program may also include catastrophic or reinsurance coverage provided under the auspices of the state. In designing the program, the director may consider a variety of service delivery and financing models including capitation payments to private physicians, a buy-in program under RIte Care and coverage arrangements purchased from qualified community health centers."

DHS is obligated to submit its plan in this regard by January 15, 2004.

4.2 What is the target eligibility group under the expansion?

4.3 How will the program be administered?

4.4 How will outreach and enrollment be conducted?

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

4.6 What will the benefit structure be (including co-payments and other cost-sharing?

4.7 What is the projected cost of coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage)

4.8 How will the program be financed?

4.9 What strategies to contain costs will be used?

4.10 How will services be delivered under the expansion?

4.11 What methods for ensuring quality will be used?

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

4.13 How will crowd-out be avoided and monitored?

4.14. What enrollment data and other information will be collected by the program and how will the data be collected and audited?

4.15 How (and how often) will the program be evaluated?

4.16 For each expansion option selected (or currently being given consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?
4.17 What has been done to implement the selected policy options? Describe the actions already taken to implement these initiatives (including legislation proposed, considered or passed, and administrative actions such as waivers), and the remaining challenges.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

4.19 How will Rhode Island address the eligible but not enrolled in existing programs? Describe Rhode Island's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

SECTION 5.

CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How ere key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full?

SECTION 6.

LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the state population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does Rhode Island have plans to conduct that research?

6.6 What organizational or operational lessons were learned during the course of the grant? Has Rhode Island proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

6.7 What key lessons about Rhode Island's insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were Rhode Island's key lessons in how to work most effectively with the employer community in Rhode Island?

6.8 What are the key recommendations that Rhode Island can provide other States regarding the policy planning process?

6.9 How did Rhode Island's political and economic environment change during the course of its grant?

6.10 How did Rhode Island's project goals change during the grant period?

6.11 What will be the next steps of this effort once the grant comes to a close?

SECTION 7.

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

7.4 What additional research should be conducted (either by the Federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?