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RHODE ISLAND: INDIVIDUAL STATE REPORT

**State-Level Field Network Study
of the Implementation of the
Affordable Care Act**



October 2016

**Rockefeller Institute of Government
State University of New York**

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RHODE ISLAND: INDIVIDUAL STATE REPORT

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Part 1 – Setting the State Context

1.1. Decisions to Date

The U.S. Department of Health and Human Services gave conditional approval to Rhode Island's health insurance exchange in December of 2012, placing the state among a group of ten others (Colorado, Connecticut, Delaware, Kentucky, Maryland, Massachusetts, Minnesota, New York, Oregon, Washington), plus the District of Columbia, to be first off the mark in moving ahead with plans for implementing the Affordable Care Act (ACA). Rhode Island had also been the first state in the nation to receive its full amount of federal money for designing an exchange, including an initial planning grant and Level One and Level Two Establishment Grants, for a total of \$81.5 million.¹ Rhode Island's accomplishments in this area reflected not only the strong support of top political leaders in the state, but also the fact that, for several years, it has had a vibrant, if inconclusive, process of health reform paralleling activity on the federal level. When the Affordable Care Act gained passage, it represented less an intimidating new challenge than a welcome opportunity to build momentum behind the tasks of expanding insurance coverage, controlling costs, and pursuing innovation in the state's health care delivery and payment systems.²

The Movement for Health Reform in Rhode Island

In 2012, approximately 12 percent of Rhode Island's population was uninsured, one of the lowest rates in the nation.³

However, health care costs in the state are high. According to the federal Centers for Medicare and Medicaid Services, Rhode Island was one of only seven states (along with Alaska, Connecticut, Delaware, Maine, Massachusetts, and New York) whose health spending exceeded \$8,000 per capita in 2009.⁴ (Washington, D.C., also belonged to this group.) Other issues of concern to health policy makers and advocates in Rhode Island included lack of effective coordination across different providers and payment sources, insufficient population-based planning, and the need for a stronger consumer orientation in the delivery of services.⁵ Competition among health insurance providers was limited given the presence of only four private companies — Blue Cross Blue Shield of Rhode Island, UnitedHealthcare, Tufts Health Plan, and Neighborhood Health Plan of Rhode Island — the last of which enrolled only recipients of the Medicaid program. In the private market, enrollments had been declining over the past several years. A recent report from a Joint Legislative Commission underscored the importance of improving the integration of behavioral health care and primary care services in the state.⁶

The origins of the movement for health reform in Rhode Island can be traced back nearly a decade. In 2007, a broad-based coalition of community organizations, business executives, union leaders, educators, and health care industry stakeholders coalesced as the group HealthRight for the purpose of advocating an agenda of system-wide health planning.⁷ Among other topics discussed by participants, the passage of reform by Rhode Island's neighboring state of Massachusetts in 2006 drew attention to the question of whether the Commonwealth's "Connector" health insurance exchange provided a model worth emulating. At the same time, Lieutenant Governor Elizabeth Roberts was increasingly orienting her office to the issue of affordable coverage. Based on recommendations from a "Healthy Rhode Island" advisory group created the year before, in 2008 Roberts introduced the Healthy Rhode Island Reform Act. Among its ambitious provisions was a new exchange structure called a "Health Insurance Access Hub" intended to provide a wide range of portable, cost-contained health insurance choices for individuals and small business owners in the state. The new health plans would also be required to meet minimum benefit standards, all made possible through the bargaining power of the Hub. Although the bill that passed ultimately did not include this HealthyHub measure, Lieutenant Governor Roberts conducted an extensive series of community meetings across the state to explain her proposal. This effort built expertise and support within the health policy community concerning insurance exchanges as a potential tool for reform.

In the period between 2008 and enactment of the Affordable Care Act in 2010, Roberts continued to explore possibilities for a Rhode Island exchange.⁸ A grant from the Robert Wood Johnson Foundation's State Coverage Initiative assisted this effort, as did

staff support from the Rhode Island Office of the Health Insurance Commissioner (OHIC) headed by Christopher Koller, long known as a strong advocate of consumer rights inside the health insurance realm. Again, Roberts and her consultants solicited input from diverse stakeholders, including insurance carriers and brokers, employers, consumers, lawmakers, providers, and more. The outcome was a report identifying four exchange-model alternatives differing according to target population and organizational structure but all assuming a role for some type of Individual Mandate.⁹ Once again in 2010, legislation was submitted in the Rhode Island Assembly establishing an exchange. And once again, the proposal failed, although the Senate did create a special commission to study health care in the state, and it made reference to the prospect of a state-based health insurance exchange to be coordinated with implementation of the ACA.

Lieutenant Governor Roberts addressed herself to this same challenge by appointing a Healthy RI Task Force consisting of more than 150 members. She charged the group with responsibility for analyzing the Affordable Care Act and guiding state decision makers toward a proactive stance aligning state and federal health reform efforts. When the report of the Task Force appeared in October of 2010, it underlined the fact that the state faced “key design issues,” such as whether to initiate its own new health insurance exchange, participate in a regional approach, or choose the default option of relying on the federal exchange projected to become operational in 2014.¹⁰ The report communicated a sense of urgency, pointing out that state enabling legislation and certain types of infrastructure development (computer resources and insurance purchasing mechanisms) needed to be acted on almost “immediately” if the ACA timetable was to be met.

One month later, in November of 2010, newly elected Governor Lincoln Chafee, an Independent, named Lieutenant Governor Roberts as lead person in charge of health reform for his administration.¹¹ He also created a Rhode Island Health Reform Commission with Roberts as chair. Other members of the commission’s Executive Committee included the state’s Health Insurance commissioner, secretary of Human Services, director of Administration, and the governor’s policy director. When signing the Executive Order forming the commission, Chafee said: “We want Rhode Island to be a national leader in terms of implementing federal healthcare reform, with the overall goal of accessible and affordable healthcare for all Rhode Islanders.”¹²

Developing a Health Insurance Exchange Under the Affordable Care Act

It was actually the Rhode Island legislature that next attempted to bring a health insurance exchange into being.¹³ During the first part of 2011, both House and Senate gave consideration to a bill formulating an exchange as a quasi-public agency to be governed by an eleven-member board. Although the Senate

passed the measure, it foundered in the House due to controversy over language inserted into the bill concerning payment restrictions for abortions. (Later, this political issue of abortion coverage and Rhode Island's health exchange would give rise to a federal lawsuit by an activist Christian group based in Arizona that was working in concert with Rhode Island Right to Life.¹⁴)

In May of 2011, the Exchange Workgroup of the lieutenant governor's Health Reform Commission commenced activity. It identified three basic performance requirements for the state's new health insurance marketplace, whatever its eventual design might turn out to be: (1) coverage options for up to 20,000 small employers and their 100,000 employees; (2) coverage options for 30,000-40,000 employees without affordable coverage available to them through their place of work; and (3) a subsidy-based program to help up to 100,000 low-income residents of the state to purchase coverage.¹⁵ The Workgroup, which was chaired by the lieutenant governor's Health Policy director, forecast at least eight future meetings between May and September at a frequency of about one meeting every three weeks and all open to the public. In tandem with this process, Health Insurance Commissioner Koller and Medicaid Director Elena Nicoletta convened an inter-agency workgroup to share information concerning the emerging exchange.¹⁶

As already noted, Rhode Island benefited from an intergovernmental transfer of resources to support development of its exchange. The Office of Health Insurance Commissioner was recipient of the state's first federal planning grant, a sum of \$1 million awarded by the Centers for Medicare and Medicaid Services on September 30, 2010. It was under the terms of this grant that Rhode Island needed to file a detailed strategy and business plan for its exchange by September of 2013. Subsequent federal monies for creating and operating the exchange were much larger in size, including a Level One Establishment Grant and a Level Two Establishment Grant that went again to the Office of the Health Insurance Commissioner via its fiscal agent, the Rhode Island Department of Business Regulation.

Sidestepping the legislative impasse over the abortion issue, Governor Chafee decided in September of 2011 to issue Executive Order 11-09 to launch the Rhode Island Health Benefits Exchange as a division of his Executive Department. For oversight, there would be an Advisory Board with thirteen members consisting of representatives from the Department of Administration, Office of Health Insurance Commissioner, the Executive Office of Health and Human Services, the Department of Health, and nine public appointees, two representing consumer organizations and two representing small businesses. Twenty-eight legislators joined with Rhode Island Right to Life in a lawsuit complaining that Governor Chafee had overstepped his powers by taking this matter out of the hands of the General Assembly.¹⁷ In July of 2013, local news sources reported that the state's "Obamacare

marketplace” would operate under the brand name of “HealthSource RI.”¹⁸

Response to the Supreme Court Decision on the Affordable Care Act

Given the state’s interest in health reform and, in particular, the insurance-exchange mechanism, it is not surprising that government officials acclaimed the June 2012 Supreme Court decision finding the Affordable Care Act constitutional. In effect, the decision provided reassurance that the long-term process of addressing health care access, cost, and quality issues within Rhode Island’s health system would continue uninterrupted. “I have fully committed to ensuring Rhode Island is a national leader in implementing health reform whatever the Supreme Court decision,” said Governor Chafee, “and this just reinforces this commitment.”¹⁹ Lieutenant Governor Roberts stated: “[T]he decision has put us ahead of the country in our focus to establish the health benefits exchange and implement other reforms, earning Rhode Island national recognition for our progress and collaboration.” Echoing Roberts’s further comments about the goal of implementing innovative solutions for the state’s health care problems, Secretary Steven Costantino of the Executive Office of Health and Human Services emphasized that “This legislation and the funding associated with it ... will empower us to aggressively integrate our fragmented delivery systems and to pursue our ongoing strategy of developing an enhanced customer service model. Rhode Island continues to be a leader in implementing the requirements of the ACA.”

Medicaid Expansion

In fact, the Supreme Court gave something less than complete endorsement to the Obama administration’s approach to health reform. Its ruling disallowed the ACA threat that states must expand eligibility for Medicaid or else lose existing federal matching payments for the program. In Rhode Island, however, this reining in of federal authority was inconsequential given the eagerness of leaders to embrace the opportunity to improve Medicaid coverage in the state. A report by Harvard Law School’s Center for Health Law and Health Policy Innovation grouped states into five categories concerning their stance toward Medicaid expansion as of July 2012: Committed, Seemingly Supportive, Seemingly Opposed, Opposed, and Undecided.²⁰ Rhode Island was one of thirteen “Committed” states at this time.

Governor Chafee subsequently obtained approval for the state’s new Medicaid guidelines by including them in his FY 2014 budget bill. Over the period from 2014 to 2017, the federal government would pay in full for newly eligible Medicaid recipients (all nonelderly adults effectively up to 139 percent of the federal poverty line), with the level of federal matching support declining to 90 percent by 2020. Rhode Island’s Health Reform Commission

had earlier estimated that 40,610 adults without coverage and having no dependent children would be affected by Medicaid expansion in 2014.²¹ According to an analysis by the Kaiser Family Foundation, 67 percent of the uninsured nonelderly population in Rhode Island, or about 84,000 people, would become eligible to receive assistance for securing coverage either through Medicaid expansion or the state's new health insurance exchange.²²

1.2. Goal Alignment

Rhode Island was quick to take an affirming response with respect to the goals of the Affordable Care Act, its process of implementation, and new opportunities for federal-state collaboration on health policy. Health reform had been identified as a major issue in Rhode Island several years before the Obama administration took office in 2009. The dual focus on coverage expansion and cost containment that was articulated by activists inside and outside of state government coincided with the aims of this 2010 federal law. Moreover, the concept of a health insurance exchange was already very familiar within Rhode Island's health policy community prior to the ACA due, initially, to Massachusetts' pioneering efforts in this area. When the Affordable Care Act became law and later when it was preserved by a narrow Supreme Court decision, many leaders in Rhode Island not only celebrated the news, they moved expeditiously to apply for federal planning monies, to create the necessary structures for mobilizing important stakeholders in devising a state exchange consistent with federal requirements, and to map a route through state government by which the exchange could become official public policy. Similarly, the Chafee administration seized on the option for Medicaid expansion under the ACA. When the health reform law survived its Supreme Court challenge, Governor Chafee's official message of appreciation was matched by informal comments expressing his exuberance: "[W]e've been moving with lights flashing, pedal to the metal, horn blaring on this initiative, and now we're validated by the Supreme Court ruling. It's good news."²³

Significantly, HealthRight also joined the chorus of support behind this Supreme Court decision, although leaders of the reform group added their hope that the law would lead to "one state-based non-profit payer of health care in Rhode Island."²⁴ Only time will tell to what extent a true synergy exists between this federal initiative and Rhode Island's longstanding interest in quality improvement and a thorough overhaul of methods of healthcare payment and delivery. Nonetheless, through the ACA's injection of resources, as well as its impetus for moving plans for an insurance exchange from drawing board to administrative reality, health reform on the federal level had energized health reform in Rhode Island, infusing it with new political capital and a tangible set of policy tools that set the stage for possibly bigger changes down the road.

Part 2 — Implementation Tasks

2.1. Exchange Priorities

In September of 2010, the Healthy RI Task Force issued a report entitled “Getting National Health Reform Right for Rhode Island” whose general tenor was that the Affordable Care Act had created a new kind of partnership between the federal government and the states.²⁵ Only by carefully analyzing the requirements and possibilities of this relationship could Rhode Island contribute effectively to national objectives while ensuring that the law operated on the state level consistent with existing health care structures, population needs, and policy mechanisms. “Federal reform does not land on a blank slate in Rhode Island,” wrote the authors. The section of the Task Force Report dealing with insurance-exchange development focused on the need for Rhode Islanders not only to decide whether to create their own exchange (versus defaulting to the federal option), but also to determine what was meant by the concept of an exchange because the word “means different things to different people, [and] the federal law allows for a wide range of definitions.”

When the Office of the Governor released its “blueprint” for the Rhode Island Health Insurance Exchange in September of 2012, the new marketplace was still a work in progress, yet important choices had been made regarding priorities and structural organization. Five key goals were listed:

1. Improve the health of Rhode Islanders.
2. Achieve near universal coverage.
3. Favorably impact health insurance cost trends.
4. Favorably impact health care delivery system effectiveness and efficiency.
5. Add value to employer health insurance purchasing.

Functionally, the work of the exchange was categorized into three components: assisting eligible Rhode Islanders in accessing new federal subsidies for the purchase of private health insurance and helping small businesses access new tax credits for offering employment-based plans; helping individuals and small businesses negotiate with health insurance carriers while monitoring quality and health outcomes; and serving as a web-based Hub for health insurance information and services for all residents of the state.

Nationwide, a variety of models exist for the design of state exchanges under the Affordable Care Act. The Henry J. Kaiser Family Foundation identifies “Quasi-governmental, Non-profit, and State-operated structures.”²⁶ Rhode Island’s approach fell under the last heading. In addition to its thirteen-member governing board described above, HealthSource RI receives guidance from an Expert Advisory Committee pooling specialized knowledge and experience about the health industry, particularly the

hospital, insurance, and professional sectors.²⁷ At one point, twenty-six members sat on this committee. (When Executive Order 11-09 was succeeded by a statute establishing HealthSource RI in 2015, a single board was created to replace the dual structure of an Advisory Board and Expert Advisory Committee.²⁸) To extend staff capacity, the Rhode Island exchange has relied on subcontractors for such technical issues as health plan certification, financial management and oversight, commercial market activities, and stakeholder support. Costs of procuring these services were high in the early development of HealthSource RI. Currently, the areas of greatest staff augmentation are data collection, analytics, project management, technology, and security staffing.

During this period of the formation and implementation of Rhode Island's health insurance exchange, three main priorities stood out. First was the commitment to readiness. The state fashioned a methodical planning process, quickly secured available federal funds, and moved ahead with high-level executive support from multiple offices and departments, among them the Governor's Office, Lieutenant Governor's Office, Office of Health Insurance Commissioner, and Executive Office of Health and Human Services. There was no delay waiting for the RI General Assembly to act when it became stalled on exchange legislation. Nor was there hesitation because of political opposition to the Affordable Care Act on the federal level, much less uncertainty over the ACA's fate before the Supreme Court. As Christine Ferguson, director of Rhode Island's health exchange, told the magazine *Governing*: "Governor Lincoln Chafee was very convincing about the need to move forward regardless of what happened with the federal legislation and the Supreme Court."²⁹ The web site for HealthSource RI went operational, as expected, in September of 2013 with announcement of the open enrollment period to begin October 1 and an explanation of the health plans to be made available. Not only did this listing include individual and family options, but also small employer coverage. Rhode Island was one of seventeen states and the District of Columbia to receive federal approval for operating a state exchange under the ACA's Small Business Health Options Program (SHOP), and it was one of only seven states to offer businesses the "full employee choice model" regarding all plans offered through SHOP.³⁰

Second, the process of building Rhode Island's exchange was broadly participatory. This reflected a stylistic approach to health reform adopted by the lieutenant governor before arrival of the Affordable Care Act; it was confirmed when Governor Chafee created a Health Reform Commission shortly after passage of the ACA; and it was elaborated in the series of steps taken to construct the exchange. As a result, HealthSource RI now occupies a position in state government defined by multifaceted ties, both formal and informal in nature, that link it with an extensive number of other state bureaucracies, interagency teams, legislative committees, commissions, advisory panels, work groups, and

vehicles for stakeholder input. Again, the new Advisory Board created under recent state law is one of the most pivotal devices by which the exchange receives input reflecting diverse areas of expertise as well as organizational and group perspectives.

Third, the architects of Rhode Island's exchange put consumers, and the public generally, front and center in the design of this new program. The Rhode Island Health Center Association was contracted to take charge of in-person Consumer Assistance activities, and another vendor was selected to create a consumer Contact Center. From July to August of 2013, HealthSource RI officials arranged meetings in all thirty-nine cities of the state to acquaint prospective users with web site features and options.³¹ More than \$1 million was expended on an advertising blitz via different media outlets.³² By April 1, 2014, HealthSource RI was reporting a total of 677,704 web site visits, 269,819 calls to the Contact Center, and 26,045 walk-in visits.³³

In November of 2013, the Rhode Island Public Expenditure Council, an independent, nonpartisan policy research group, issued its findings concerning the launch of HealthSource RI. The overall picture was highly positive.³⁴ Key points included:

- Minimum technical difficulties, in contrast with the experience of the federal health exchange HealthCare.gov.
- Enrollment of 4,405 individuals in the first month of online sign-ups, of which 3,213 were enrollees for the state Medicaid program and 1,192 were registrations for private health insurance.
- Premiums among the lowest in New England (although with higher than average deductibles for the region).

By March 31, 2014, more than 92,000 Rhode Islanders had signed up for coverage, counting the exchange's individual private insurance customers and enrollees in the Medicaid program.³⁵ Again, the bulk of enrollments were for Medicaid, by a ratio of about 2.3 to 1. An additional 1,100 took advantage of options made available through the small employer program. Prior to opening of the exchange, it was estimated that 124,000 Rhode Island residents lacked insurance coverage. How many new enrollees were previously uninsured? What percentage would fail to meet their premium obligations? The answers to these questions were unknown. Nonetheless, the program metrics were striking. Private insurance enrollments and, even more so, Medicaid sign-ups far surpassed the state's projections.

2.2. Leadership – Who Governs?

Fast forward to 2016, and HealthSource RI has now had three directors over the relatively brief period of its existence. These individuals differ in their professional backgrounds and in the skill sets and types of knowledge brought to the job. The tasks faced by these leaders have also varied due to the rapid evolution of HealthSource RI and the changing political context in which it operates.

Governor Lincoln Chafee announced the appointment of Christine Ferguson as the state's first director for its new health exchange in June of 2012.³⁶ At the time, Ferguson held an appointment on the faculty of George Washington University in the area of health policy. This position capped decades of experience in the public sector. Trained as a lawyer, Ferguson was on the staff of Rhode Island Senator John Chafee, Lincoln Chafee's father, for approximately fifteen years during the 1980s and early 1990s. Subsequently, she became director of the Rhode Island Department of Human Services from 1995 to 2001. From 2003 to 2005, Ferguson was commissioner of Public Health in Massachusetts under Governor Mitt Romney. In 2009, Ferguson made an unsuccessful bid for election to the U.S. House of Representatives from Rhode Island's first district, using her campaign to put forward a plan to allow small businesses to purchase health coverage for their employees from the state's Medicaid program.³⁷ In this same year, she became a board member of Blue Cross Blue Shield of Rhode Island. Ferguson stated publicly that she viewed the Affordable Care Act as the fulfillment of market-oriented health legislation she helped develop for Senator Chafee in 1993 as an alternative to President Bill Clinton's embattled Health Security Act.³⁸

Without doubt, Ferguson's résumé was exceptional. Well versed in the operation of the health sector, she was also a veteran of the worlds of state and federal government and familiar with matters administrative and legislative. She had many ties of a personal and professional nature in Rhode Island. In the time frame leading up to adoption and implementation of the Affordable Care Act, she interacted regularly with key players on the Rhode Island health policy scene. A Republican, she had maintained cordial relations with lawmakers on both sides of the aisle, as well as state administrators, members of the reform group HealthRIght, and Rhode Island's major foundation. She also embraced the need for health reform wholeheartedly, believing that HealthSource RI held the potential not only to serve as a vehicle for brokering affordable health insurance, but also to become a powerful new institutional player guiding the restructuring of Rhode Island's health system.

Selection of someone with Ferguson's stature accented the seriousness with which Governor Chafee approached the launch of Rhode Island's health insurance exchange. Ferguson went on to gain widespread praise for the speed with which she and her team brought her new agency online and carried out its mission of enrolling thousands of subscribers in Qualified Health Plans. The contrast with the fumbled rollout of the federal health insurance plan during this period was striking. In an article in *Governing* magazine in May of 2013, the author wrote: "If the exchange is a corporation, then [Ferguson] is its CEO. She plays the role well; during a board meeting, she's the one with all the answers, the person to whom participants direct their questions."³⁹ The article described Ferguson as "the one responsible for transplanting the

commercial start-up mentality into the Rhode Island State House.” Mark Patinkin, a long-time columnist for the *Providence Journal*, called Ferguson Rhode Island’s “Obamacare czar,” and commended her for countering the notion of “government incompetence” so prevalent in the media.⁴⁰

Ferguson’s prominence, however, which stood her in such good stead during the founding of HealthSource RI, would eventually become a drawback of sorts. Complaints mounted about the exchange’s high costs in the face of declining federal support. Not everyone supported Ferguson’s expansive sense of mission regarding new directions for health service delivery and cost containment. In this atmosphere, the moniker of health “czar” perhaps did not serve Ferguson well. When Democrat Gina Raimondo won the governorship in 2014, she made known her intention to replace Christine Ferguson as part of the process of building her own administrative team.

The second head of HealthSource RI was Anya Rader Wallack. In announcing Wallack’s appointment, Governor Raimondo graciously congratulated Ferguson on a job well done: “Christy exhibited vision and tenacity under difficult circumstances to implement the affordable health care act. She helped create our health exchange from scratch in order to make health care more accessible to Rhode Island families and businesses. We appreciate her service to our state.”⁴¹ At the same time, the appointment of Wallack signaled the governor’s desire for a different type of leadership to take HealthSource RI into the next era of state government with a focus on making the exchange “a sustainable and affordable organization that provides clear return-on-investment to Rhode Island Families and employers.”

Wallack did not have precisely the same kind of lengthy high-profile career in the public arena as Ferguson, which had spanned administrative, legislative, and electoral spheres. Nor did Wallack’s background include much prior professional experience in Rhode Island. Despite having maintained a residence in Little Compton for sixteen years, her involvement consisted chiefly of brief consultations with the Rhode Island Offices of Health Insurance Commissioner and Lieutenant Governor. She also had been invited to speak at a local conference as an expert on state health reform. But Wallack possessed the advantage of injecting new blood and a fresh perspective into a policy-making environment characterized by entrenched relationships and modes of thinking. She also had the benefit of working in two other states well known for their own brands of health policy innovation.

Wallack earned her doctorate in social policy from Brandeis University’s Heller School. Before joining HealthSource RI, her most notable position was chair of the Green Mountain Care Board in Vermont between 2011 and 2013, a role that made her responsible for monitoring health reform efforts in her home state. Previously, Wallack had been on the health policy staffs of both Governors Shumlin and Dean. She also ran the Vermont Program

for Quality in Health Care. After leaving Vermont, Wallack did stints as interim president of the Blue Cross Blue Shield of Massachusetts Foundation and executive director of the Massachusetts Medicaid Policy Institute. She later founded Arrowhead, a health care consulting company based in Fall River, Massachusetts.⁴²

In March of 2015, Wallack gave an interview to Rhode Island Public Radio revealing her thoughts as she settled into the new position with HealthSource RI.⁴³ Pleased to note the growth of enrollment in plans offered by the exchange, Wallack vowed active outreach to eligible residents of the state and the state's small business community. Her highest priority, however, would be addressing an "unacceptable level of problems" in customer service. Wallack discussed the pressure of meeting the requirement that HealthSource RI become fully independent of federal funds by Fiscal Year 2017, a situation that necessitated shifting expenditures and programmatic commitments to create a "lean mean operation." The interview communicated Wallack's in-depth understanding of the health sector as well as her determination to consolidate her agency's position in changing times. However, hers was a constrained view of the health exchange compared with that of her predecessor, a focus on management proficiency at a time of looming difficulties. In a presentation to her Advisory Board in early 2015, Wallack stated: "HSRI must have a business plan and build a budget that is right-sized and based on performing only core ACA functions."⁴⁴ This contrasted with Ferguson's inclination "to think big" in positioning HealthSource RI as a powerful force for health reform in the state.⁴⁵ Nonetheless, Wallack's tempered view and steady hand proved to be just what was needed to achieve Governor Raimondo's dual goals of writing HealthSource Rhode Island into state law and convincing lawmakers to approve funding for its survival.

As it turned out, Wallack would not be at HealthSource RI long enough to fully carry out her agenda. Less than a year after taking control of the health exchange, she accepted a new appointment from the Raimondo administration to become director of the state's Medicaid program, filling a critical post vacated when the existing head of Medicaid resigned in September of 2015. Wallack's transfer was a logical move given her knowledge of Medicaid going back to her time at the Massachusetts Medicaid Policy Institute, not to mention her thesis on the program at Brandeis. She also had effective working relationships with the governor and Secretary of Health and Human Services Elizabeth Roberts. Moreover, as health policy analysts in Rhode Island had underscored from the very birth of HealthSource RI, the functioning of the exchange and the Medicaid program were "fundamentally inextricable."⁴⁶ Wallack's assumption of the Medicaid directorship promised a level of interagency coordination, a shared sense of mission, that could only redound to the benefit of both units of government. Nonetheless, Wallack's departure from HealthSource RI, coming so soon after her replacement of Christine Ferguson, introduced an element of instability in leadership

of the exchange just as it faced the challenge of streamlining internal operations and an upwelling of criticism from inside the legislature and elsewhere. Wallack's stay with the Medicaid program would last eleven months, until her move in October of 2016 to join Brown University's School of Public Health in a program manager role.⁴⁷

The third individual to become director of HealthSource RI was Zachary Sherman, who continues in this post today. Sherman was a case of promotion from within, someone who provided a bridge between the tenures of Ferguson and Wallack at the agency. Sherman had been part of the group that designed and launched the health exchange after it was authorized by Executive Order in 2011.⁴⁸ After a brief exit from state government, Sherman returned to the exchange in 2015 once Wallack became director and tapped him to serve as her chief of staff. Sherman also acted as interim chief financial officer of the agency for a number of months.

Unlike Ferguson and Wallack, Sherman did not possess a long record of accomplishment in the health care field. A student of business administration in college, he joined Wallack's private health policy consulting group upon graduating in 2010. After first being named acting director of HealthSource RI in November of 2015, Sherman became its permanent director in March of 2016. His style has proved to be low-profile compared to Ferguson and Wallack, with a decided management orientation focused on meeting enrollment and budgetary targets and coming to grips with persistent customer service issues. Sherman's work at the health exchange did not represent an opportunity to pursue ideas and ideals about health reform incubated in other settings — something that was true of both Ferguson and Wallack, in different ways. Instead, he applies a set of generalist business skills to, what is for him, a relatively new policy domain. Upon becoming HealthSource RI director in March, he told a newspaper reporter: "My education in health policy has been immersing myself in this job."⁴⁹

So far this examination of leadership has emphasized the executives of HealthSource RI. But an important bureaucratic component of leadership also merits attention, and that is the board with whom directors have been required to consult in designing the exchange and determining its role within the health care sector of the state. As stated in an earlier section of this report, the institution of an oversight group was a central feature of Governor Chafee's Executive Order in September of 2011. For the Exchange Advisory Board to play a meaningful role, its composition had to capture specialized expertise about health policy and the health care system in Rhode Island while also including members from key stakeholder groups. The relevant section of Executive Order 11-09 stated the following requirements pertaining to governance of the Rhode Island Health Benefits Exchange (RIHBE).

Board — Establishment. There is hereby established within the Division of the RIHBE a Board, which shall consist of thirteen members as follows: the Director of the

Department of Administration or his or her designee; the Health Insurance Commissioner or his or her designee; the Secretary of the Executive Office of Health and Human Services or his or her Designee; the Director of the Department of Health (the “Health Director”) or his or her designee; and nine members to be appointed by the Governor from the general public, two of whom shall represent consumer organizations and two of whom shall represent small businesses. The balance of the appointments to the Board shall be made to provide demonstrated and acknowledged expertise in a diverse range of health care areas including, but not limited to, the following: individual health care coverage; small employer health care coverage; health benefits plan administration; health care finance and accounting; administering a public or private health care delivery system; state employee health purchasing; electronic commerce; and promoting health and wellness. The expertise of the other members of the Board shall be considered and appointments shall be made so that the Board’s composition reflects a range and diversity of relevant expertise, skills, backgrounds, and geographic and stakeholder perspectives.

To guard against direct conflict of interests, the Executive Order added the following controls:

Board – Conflicts of Interest. No member of the Board or of the staff of the RIHBE shall be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, an insurer, a health insurance agent or broker, a health care provider, or a health care facility or health clinic while serving on the Board or on the staff of the RIHBE. No member of the Board or of the staff of the RIHBE shall be a member, a board member, or an employee of a trade association of insurers, health facilities, health clinics, or health care providers while serving on the Board or on the staff of the RIHBE. No member of the Board or of the staff of the RIHBE shall be a health care provider, unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

At the outset, then, HealthSource RI was guaranteed a high-powered Advisory Board by virtue of the designated seats to be filled from within state government including, most notably, the director of Administration, secretary of the Executive Office of Health and Human Services (EOHHS), commissioner of OHIC, and director of Health. The “public” members of the board have also been carefully chosen to complement this governmental representation with individuals from the provider, business, and union sectors, as well as community groups. The Lieutenant

Governor's Office convened and initially staffed the Advisory Board. It also established small interagency groups to "dive deeply into how to operationalize our shared vision" of the exchange.⁵⁰ The Advisory Board had its first meeting on November 8, 2011, and met regularly until March of 2015. As noted in Section 2.1. above, Rhode Island Chapter 42-157 streamlined this advisory structure by converting the existing Advisory Board and a secondary Expert Advisory Committee into a single Exchange Advisory Board, but without sacrificing the commitment to broad-based input. After the new governor updated appointments to this board, it began meeting again in May of 2016.

2.3. Staffing

Staffing for HealthSource RI grew quickly during the agency's first few years. According to state budget documents, the exchange employed 15.0 FTEs in Fiscal Year 2013.⁵¹ This jumped to 19.0 FTEs in the next fiscal year. By Fiscal Year 2017, it had fallen back to 16.0 FTEs. These numbers include "Classified" and "Unclassified" staff as well as any "Interdepartmental Transfers," "Cost Allocations from other Programs," and "Turnover" that took place in a given year. Between Fiscal Years 2013 and 2017, the payroll costs associated with these FTEs rose from \$1.47 million to \$2.59 million. It should be noted that, throughout the life of the exchange, many important functions, such as building the web site, information technology, interface with Medicaid eligibility systems, analysis of commercial insurance products and options, and operation of the consumer Contact Center, have been outsourced through contracted entities whose workers are not reflected in these staffing totals. These purchased services have always represented the bulk of HealthSource RI's budget expenditures, which rose as high as \$50.8 million in FY 2015 and then fell sharply to \$12.4 million in FY 2017.

2.4. Outreach and Consumer Education

Given her belief in the market dynamics of health reform, Christine Ferguson prized strong consumer education efforts. During the roll-out period for HealthSource RI, she once gave a briefing in which she referred to the exchange as a kind of classroom, arguing that "What we're doing is really shining the light on how insurance works and how we can change it collectively as well as individually through our choices."⁵² Ferguson backed up these words with a steadfast commitment to publicize and explain the operations of her agency. This same orientation has continued to mark the activities of her successors.

In July of 2013, HealthSource RI launched its "39 in 3" campaign, hosting group meetings in all thirty-nine Rhode Island cities and towns over three months to educate individuals, small employers, and community organizations about the health coverage options being made available through the exchange. Shortly after, HealthSource RI also contracted with marketing firms to

begin a campaign that included print, television, radio, bus shelter, and billboard advertisements to raise awareness of the exchange among all Rhode Islanders.⁵³ Developed by NAIL Communications of Providence, this effort linked the new health exchange to other moments in history when Rhode Island had led the nation in progressive causes. Print advertisements featured an image with a flag blowing in the wind and emblazoned with the words “Freedom of Speech, Freedom of Assembly, Freedom of Healthcare.” Spokesman Ian Lang informed *The Providence Journal* that HealthSource RI planned to spend \$837,000 on advertising during the last quarter of 2013: “It’s to drive awareness and to build a positive association with the brand.”⁵⁴

In January of 2014, HealthSource RI began airing a new wave of television advertisements, this despite the fact that enrollment targets for the first Open Enrollment period had already been exceeded. According to an article in *The Providence Business News*, “Executive Director Christine Ferguson hopes to boost the exchange’s enrollment figures further through the advertising outreach, as well as a series of public enrollment events scheduled through early March.”⁵⁵ Also announced was use of social media to acquaint eligible consumers with exchange offerings.

Grassroots organizing is most effective when conducted by experienced grassroots organizers. HealthSource RI contracted with the Health Initiative of the nonprofit group Providence Plan to conduct outreach to small businesses. The Health Initiative was already managing monthly meetings as well as communications for the state’s Small Employer Taskforce through a contract with the Office of Health Insurance Commissioner. In addition to this work with small businesses, the Health Initiative took on oversight responsibility for the HealthSource RI Outreach Team, with a particular focus on community-based presentations and enrollment-promotion events.⁵⁶

Instilled with a consumerist mentality from the start, HealthSource RI has continued to make outreach and education a priority, albeit within the limits of a declining budget, including a cut from about \$2 million to \$400,000 for advertising between FY 2015 and FY 2016.⁵⁷ Current projects include web site improvements to help consumers compare health plans and complete enrollments. Getting technical assistance has been simplified. The agency has posted an extensive glossary of terms to help customers “learn the language of health care.” Outreach events take place throughout the year to address the special circumstances under which enrollments may be possible outside Open Enrollment periods. Additionally, during this fall of 2016, HealthSource RI has been holding an ongoing series of public Enrollment Events in local communities, resorting to a targeted email campaign to boost attendance.⁵⁸ This kind of ramping up is typical in anticipation of an upcoming Open Enrollment period. Several months earlier, the agency had reopened its East Providence Walk-In Center while relocating its Contact Center to the same building with

expanded operating hours. These steps represented “part of ongoing efforts to improve the customer experience.”⁵⁹

Not just information but rights, as well, matter to health care consumers. The Rhode Island Office of Health Insurance Commissioner used funds provided under the Affordable Care Act to support a consumer assistance partnership with the Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH). A total of 13 percent of all RIREACH clients in 2014 were insured through HealthSource RI. Another 26 percent were Medicaid recipients. Cases ranged from problems getting coverage to difficulties with accessing care, or payment for services, once enrollees had signed up for coverage.⁶⁰

2.5. Navigational Assistance

The function of Navigational Assistance was among the essential items supported by awards from the federal Centers for Medicaid and Medicare Services to Rhode Island for building its health insurance market place. Level One grants included funding for the purpose of developing “a robust In-Person Assister Program” and also to operate HealthSource RI’s Contact Center through 2014.⁶¹ Level Two grants extended this support for the Contact Center, including specific resources for technical fixes to reduce waiting times for consumers and to backup customer service representatives when “complex policy and technology issues” arose.

In practice, HealthSource RI has developed a range of options whereby enrollees can receive information and assistance regarding their insurance applications. Three alternatives prominently presented on the exchange web site include scheduling a meeting with a Navigator, going to a Walk-in Center, and telephoning a health insurance Expert. Navigators are individuals who have undergone training and certification by the Rhode Island Health Center Association (RIHCA), according to the terms of a contract with HealthSource RI. As of summer 2016, the exchange web site indicated the availability of more than 100 Navigators across the state, and it allowed consumers to search for a suitable contact based on such criteria as agency and geographic location and language spoken.

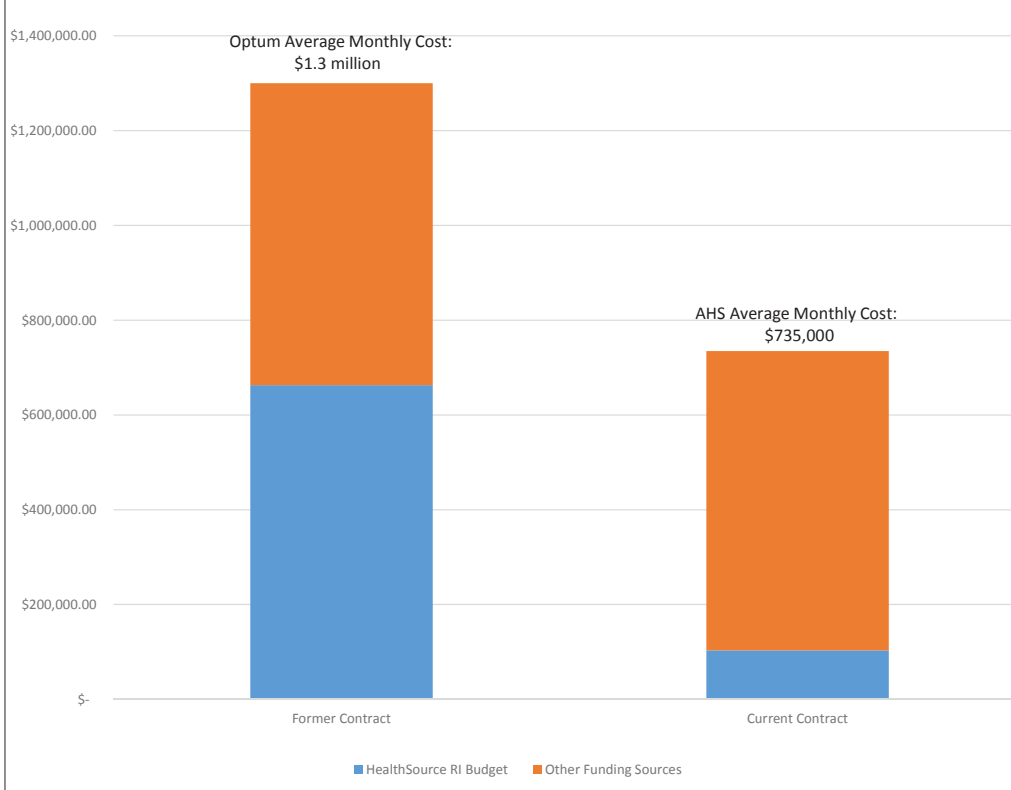
Two additional assistance options should also be noted. One is to consult a Certified Application Counselor, a group also trained by RIHCA and based in community organizations around the state that have volunteered to supply free enrollment assistance for HealthSource RI. The other is to work with a licensed insurance agent or broker, without charge, to determine coverage eligibility, compare plan features, and undertake the application process. In contrast with Navigators and Counselors, insurance professionals are allowed to actively advise and make recommendations to consumers concerning their plan choices.

Without doubt, the HealthSource RI administrative team has given abundant attention to consumer assistance, devising a services approach marked by flexibility as much as multiplicity. All this effort, however, has not managed to produce a trouble-free enrollment experience for consumers. Labeling the rollout of the health exchange in 2013 as “imperfect yet hopeful,” one reporter described sometimes lengthy and unproductive meetings between applicants and Navigators that were accompanied by frustrating information gaps and web site bugs.⁶² These initial difficulties were predictable, given the newness of the state’s enrollment enterprise and the onslaught of consumer interest it had sparked. A representative from HealthSource RI stated that, in the exchange’s first day-and-a-half, the Contact Center had received 2,198 calls, there were thirty walk-ins, the web site had more than 10,000 visitors, and 252 applications were processed.

Yet consumer assistance problems have outlasted this early phase of exchange operations, taking the form of excessive waits on the telephone line, clumsy online application procedures, application processing errors, and insurance payment snafus.⁶³ Exacerbating the challenge of implementing any kind of comprehensive fix has been HealthSource RI’s declining budget. Out of fiscal necessity, the main “Contact Center” for Walk-In and Drop-Off services was temporarily demoted to a Drop-Off location only in 2015, while more than 100 Contact Center staff lost their positions. No longer would calls be taken on weekends. HealthSource RI has attempted to cope strategically by upsizing staff during enrollment periods and by coordinating with the Department of Human Services for optimal handling of Medicaid-related calls. Speaking on the eve of her departure from the agency, Director Wallack admitted: “There isn’t a day that goes by that we don’t hear some complaints.”⁶⁴ HealthSource RI statistics for the Open Enrollment period from November 1, 2015, to January 31, 2016, indicate a 27 percent drop in Contact Center call volume from the previous year (163,297 versus 247,863). This decline coincided with the agency’s decision to adopt auto-enrollment renewals during its third Open Enrollment, moving away from the more active enrollment procedures of 2014-15. On the other hand, a huge increase was recorded in the number of unique visits to the exchange’s Navigator directory, from 4,224 to 47,758. There was also an uptick in the number of Navigators and Certified Application Counselors active at HealthSource RI or one of its partnering agencies, from 170 in 2015 to 185 in 2016.⁶⁵

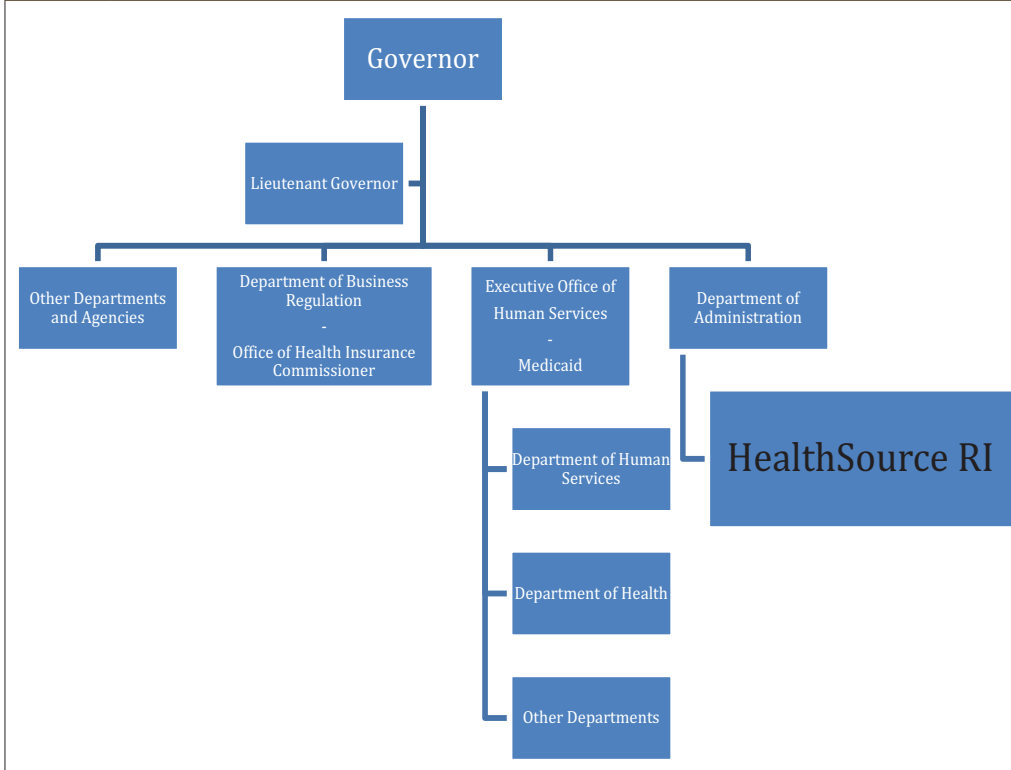
In March of 2016, newly appointed head of HealthSource RI Zachary Sherman identified customer service as one of his main concerns in the face of frequent criticisms about this area. Around this same time, the state announced it would be changing private vendors for its Contact Center from a company named Optum, a health services entity connected with UnitedHealthcare, to Pittsburgh-based Automated Health Systems.⁶⁶ The average monthly cost of Optum’s twenty-eight-month contract had been \$1.3 million, with about

Figure 1. Contracted Vendor Services for HealthSource RI Contact Center



\$660,000 coming from HealthSource RI. Automated Health System’s contract, which runs seventeen months, will average \$735,000 per month, of which the exchange is responsible for \$103,000. (See Figure 1.) The discrepancy in the overall size of these two contracts, and the smaller proportion to be absorbed by HealthSource RI, underscores the scaling down that is taking place at the agency combined with greater fiscal participation in the enrollment process by Rhode Island’s Medicaid agency.

Figure 2. Placement of HealthSource RI Within Rhode Island State Government



2.6. Interagency and Intergovernmental Relations

The environment in which Rhode Island’s state-based exchange was created and implemented can be characterized as a complex combination of state agency structures and relationships meant to promote sharing of responsibilities, resources, and authority. The overall bureaucratic setting in which HealthSource RI was cast organizationally is shown in Figure 2.

As discussed earlier, HealthSource RI was originally established in 2011 via

Executive Order, not legislative statute. It was necessary for this Executive Order to be drafted as the implementation of a previously established state law, based upon the authorized powers and duties of an existing state agency. This situation remained in force until 2015, when the Rhode Island General Assembly finally enacted Chapter 42-157 confirming, and giving statutory basis for, the exchange's existence.

Authority for Rhode Island's newly created Health Benefits Exchange initially was embedded in the multifaceted statutory mission of the Rhode Island Department of Health, including the provision "to provide benefits for persons lacking adequate insured coverage and to lower costs or improve the quality, availability and accessibility of health services." This authority, as interpreted by the Governor's Office when it formulated Executive Order 11-09, provided "the power to administer funds to expand benefits for people who lack insurance coverage."⁶⁷

In Rhode Island, the Department of Health is one of four departments falling under the umbrella of the EOHHS. However, neither the Department of Health, nor EOHHS, was selected by the governor as the administrative unit to house the exchange. This decision raised concerns at the time. Overseeing various public benefits programs and public hospitals, EOHHS is also the single state Medicaid agency. According to then-Secretary Steven Costantino, the agencies and departments within EOHHS possessed statutory authority for much of the mission proposed by the governor for the new exchange. Costantino indicated "a lot of sensitivity to some of the issues that may be overlapping."⁶⁸

Nor was OHIC selected as the unit to operate the exchange, despite the fact, already discussed, that OHIC had been recipient of the first federal exchange planning grant to Rhode Island. OHIC had, in fact, been conceived in 2004 to play an expansive health policy role in the state, one well beyond traditional health insurance regulation. OHIC is charged with "Guarding the solvency of health insurers ... Protecting the interests of consumers ... [Improving] the quality and efficiency of health care service delivery and outcomes."⁶⁹ Over time, OHIC has become a lead agency in working toward affordable and comprehensive health coverage for the citizens of Rhode Island.

Despite this overlap of responsibilities between the new exchange and both EOHHS and OHIC, then, a relatively autonomous exchange took shape under Executive Order. Functionally, the exchange became a component of the administrative and fiscal arm of the Executive Branch, the Rhode Island Department of Administration. Further, the exchange was physically located initially within the governor's suite of offices in the Statehouse, providing easy access to the governor and lieutenant governor. The governor's rationale behind this organizational preference was to allow for the development of an agency that could relate easily with insurance companies, businesses, and the general public unrestrained by some of the complicated missions and

relationships of existing bureaucratic departments. This administrative placement also seemed advisable for enhancing the nimbleness of HealthSource RI in carrying out its hiring and procurement activities. Finally, state officials wanted to create a health exchange having its own independent identity, rather than subsuming it to another existing unit such as the Medicaid Office whose public image, in some quarters, suffers due to an association with the welfare program.

2.6(a). Interagency Relations. A few examples of programmatic activities central to Rhode Island's new exchange serve to illustrate the inherent interdependency of HealthSource RI and other state departments and agencies, as well as the way in which this interdependency has been managed in practice.

Shortly after its launch, HealthSource RI needed to develop an integrated application and eligibility determination system for Medicaid enrollees and for the assignment of federal tax credits to enhance health insurance affordability for low-income subscribers. This task required a great deal of coordination between the exchange and EOHHS with respect to the implementing time frame, financing, and policy decision-making relative to the exchange's outreach and customer service functions.

As it played out, HealthSource RI became an integral part of the state's Unified Health Infrastructure Project (UHIP) for verifying Medicaid eligibility and premium subsidies through the exchange (see Section 2.8 below). The mechanism developed has been put into service for eligibility determination functions at other public assistance programs in the state as well.

Also of critical importance, in April of 2012 the state issued a Request for Proposal (RFP) to create the exchange's information and technological infrastructure. The evaluation committee responsible for selecting a vendor from those responding to the RFP consisted of all state agencies involved with the exchange, including the Department of Administration, EOHHS, and OHIC.⁷⁰ Again, this scenario demonstrates the value placed on the sharing of expertise, and giving other governmental stakeholders a voice, in the technical realization of HealthSource RI's mission.

After legislative proposals to create a state-based exchange in RI failed to pass in 2011, it gave rise to continued discussion within the legislature about the role and future identity of HealthSource RI. The leadership of the exchange was centrally involved in these deliberations, which spanned a period of several years, by such means as testimony before House and Senate Finance Committees and other contacts. During the first week of the 2015 legislative session, the General Assembly issued a press release with the following headline: "Rhode Island must decide what to do about HealthSource RI, the state-administered health insurance marketplace, as cuts loom in federal assistance for its administration." The release went on to state that "This fiscal reality prompted Chairmen Daniel Da Ponte and Joshua Miller to hold a joint meeting of the Senate Finance Committee and Senate

Health and Human Services Committee ... where members of both committees listened to testimony from and posed a series of probing questions to former Rhode Island health insurance commissioner Christopher Koller, now the president of the Milbank Fund, a national foundation that offers advice on health care policy."⁷¹ Here was another vital form of cross-government relations in the evolution of HealthSource RI, reflecting the pivotal role OHIC had played in steering this agency from the start.

Ultimately, in 2015, when lawmakers adopted Chapter 42-157 to create a statutory basis for the exchange, it was an attempt to resolve significant budgetary and programmatic issues associated with the maturation of HealthSource RI as a bureaucratic entity in addition to the phase-out of long-term federal support. The nature of these issues, and the remedial options that came under consideration, will be discussed at greater length in the Summary Analysis section of this report.

2.6(b). Intergovernmental Relations. Neither the Rhode Island Medicaid Program, nor HealthSource RI, utilizes municipal or county governments to provide eligibility screening for Medicaid or the exchange. In addition to the online portal and statewide Contact Center of HealthSource RI, regional offices of the state Department of Human Services, an agency under the EOHHS umbrella, provide Medicaid intake and eligibility services.

On a multistate level, The New England States Collaborative for Insurance Exchange Systems (NESCIES), also known as the Massachusetts Early Innovator Cooperative Agreement, was formed for its members to share their technology and administrative experience in creating health insurance exchanges. Exchange collaboration among Rhode Island and the five other New England states is reportedly the largest such multistate effort in the country. Funding for this initiative came from a 2011 grant for \$35.5 million from the federal Centers for Medicare and Medicaid (CMS). The purpose of the award was to produce Health Insurance Exchange IT components that would be "consumer-focused, cost-effective, reusable, and sustainable."⁷² Participating states, working with support from the University of Massachusetts Medical School and The New England States Consortium Systems Organization (NESCSO), have also used their regional meetings to investigate opportunities for multistate procurement and other collaborative efforts.⁷³ Rhode Island's involvement is in line with section 42-157-5 of the state's new health exchange statute, which specifies the following on the subject of regional purchasing, efficiencies, and innovation: "To take advantage of economies of scale and to lower costs, the exchange is hereby authorized to pursue opportunities to jointly negotiate, procure or otherwise purchase exchange services with or partner with another state or multiple states and to pursue a Federal Affordable Care Act 1332 Waiver."

2.6(c). Federal Coordination. Relationships between federal agencies and HealthSource RI have been characterized, generally, by the theme of partnership. At the June 2013, meeting of the Rhode Island Health Benefits Exchange Advisory Board, Director Ferguson reported active communication with CMS and its Center for Consumer Information and Insurance Oversight (CCIIO) about the exchange approval process. She stated that the federal government had been “working closely” with the state “to ensure that the state will be successful” in creating a fully functioning, state-based exchange by October 1, 2013.⁷⁴

According to Director Ferguson’s letter to Governor Chafee near the end of her tenure at the exchange, the state had received more than \$150 million in federal grants to assist with the establishment and implementation of HealthSource RI. Helpfully, federal officials had also agreed to extend the period during which some of those funds could be spent in order to sustain exchange operations into 2016.⁷⁵

The interaction between state and federal actors did grow tense at times, as when federal databases, necessary for confirming income and verifying the identity of HealthSource RI applicants, failed to function properly in late 2013. State officials described these issues as mere “glitches,” however, and state-level solutions were devised.⁷⁶

2.7. QHP Availability and Decisions To Date

2.7(a). Qualified Health Plans (QHPs). A Qualified Health Plan is one that has been certified as suitable for offering on a federal or state health exchange under the Affordable Care Act. Plans are categorized either as Platinum, Gold, Silver, or Bronze, according to their comprehensiveness and costs. The standard needing to be met is a benefit package that minimally provides ten “Essential Health Benefits” specified by the federal government and with limited cost sharing imposed on the subscriber. In determining its response to the Essential Health Benefit requirement in 2012, Rhode Island opted for Vantage Blue, a preferred provider organization (PPO) product from Blue Cross Blue Shield of Rhode Island, as its coverage benchmark.⁷⁷ For plan year 2017, Rhode Island has confirmed that selection.

HealthSource RI’s first Open Enrollment period included twenty-eight different plans from three insurers – Blue Cross Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and UnitedHealthcare.⁷⁸ Twelve plans were offered on the individual market, and sixteen were offered in the Small Business Health Insurance Options Program. UnitedHealthcare offered plans solely for SHOP. The individual plans fell into Gold, Silver, and Bronze metal tiers, providing varying cost and benefit options. (There was also a plan in the “Catastrophic” category, and Platinum plans existed for SHOP but not for individuals.) Subsequent analysis showed that, while enrollees in the individual market favored plans in the Silver category by a large margin

(15 percent Gold, 62 percent Silver, 22 percent Bronze), those in the employee market favored Gold plans (48 percent Gold, 23 percent Platinum, 21 percent Silver, 8 percent Bronze). This differential between the exchange's two component parts reflected several things, such as employer contributions toward the cost of coverage in SHOP, the presence of Platinum plans in SHOP but not on the individual side of the exchange, and the availability of federal Cost Sharing Reductions for individuals who chose a Silver plan.

The Rhode Island Public Expenditure Council compared premium rates and cost sharing in HealthSource RI with exchanges elsewhere in New England.⁷⁹ Rhode Island's premiums were among the lowest. Based on average premium rates for individuals at three different age levels (twenty-one years, forty years, sixty years) who enrolled in Silver plans, Rhode Island was one of the two bottom states for twenty-one-year-olds and forty-year-olds. For sixty-year-olds, it was in the top three states. In general, premium rates in Rhode Island more closely approximated those in the states of New Hampshire and Maine, two federal-run exchange states, than those in Connecticut, Massachusetts, and Vermont, fellow state-run exchange states. An analysis of cost sharing examined average plan deductibles for the three metal levels. In every comparison, Rhode Island had the second highest deductibles of the group. Overall, the conclusion of the analysis seemed clear that a complex of factors, in addition to an exchange's set-up and auspices, figured into exchange performance and insurance cost outcomes.

For the second and third Open Enrollment periods, enrollees in the individual market continued to rise, from 25,767 for plan year 2014, to 30,001 for plan year 2015, and 34,888 for plan year 2016.⁸⁰ Customers also had a greater range of choices. For plan year 2015, there were twenty Gold, Silver, and Bronze metal plans, and for plan year 2016, there were twenty-seven in these same three categories. A substantial part of the increase in insurance options came from UnitedHealthcare's entrance into the individual market, which began in 2015. Overall, Silver plans have retained their dominance, rising to 65 percent of individual enrollees in 2015 and 69.8 percent in 2016. Neighborhood Health Plan's COMMUNITY silver plan became the most popular choice of all plans on the exchange in 2015, and it captured this position again in 2016.

Table 1 presents selected indicators for plan years 2015 and 2016 concerning the monthly premiums for a twenty-one-year-old subscriber and maximum annual out-of-pocket payments (MOOP) for all plans on HealthSource RI's individual market. With only rare exceptions, premiums increased from one year to the next. However, the typical increase was modest, in the range between 3-5 percent. MOOP changes were somewhat more inconsistent, but generally the figures for 2016 resembled those for 2015. Data in this table do not reflect the federal Cost Sharing Reductions received by most Silver plan enrollees.

**Table 1. HealthSource RI Premiums and Maximum Out-of-Pocket Payments 2015 and 2016 Plan Years
(Premiums Are for Twenty-One-Year-Olds Prior to Any Tax Credit)**

	<i>2015 Plan Year</i>	<i>2016 Plan Year</i>	<i>Percentage Change</i>
PREMIUMS			
GOLD			
Lowest Premium Plan	\$239	\$250	4.6
Highest Premium Plan	\$299	\$314	5.0
Average Premium All Plans	\$266	\$277.25	4.2
SILVER			
Lowest Premium Plan	\$191	\$203	6.3
Highest Premium Plan	\$251	\$263	4.8
Average Premium All Plans	\$222	\$224.44	1.1
BRONZE			
Lowest Premium Plan	\$157	\$158	0.6
Highest Premium Plan	\$197	\$203	3.1
Average Premium All Plans	\$178.17	\$179.86	0.95
MAXIMUM OUT-OF-POCKET PAYMENTS (MEDICAL + DRUG)			
GOLD			
Lowest MOOP Plan Individual	\$2,250	\$2,500	11.1
Highest MOOP Plan Individual	\$4,000	\$4,000	0.0
Average MOOP Plan Individual	\$3,541.67	\$3,468.75	-2.1
SILVER			
Lowest MOOP Plan Individual	\$4,000	\$4,000	0
Highest MOOP Plan Individual	\$6,600	\$6,800	3.0
Average MOOP Plan Individual	\$5,700	\$5,716.67	0.29
BRONZE			
Lowest MOOP Plan Individual	\$6,350	\$6,550	3.2
Highest MOOP Plan Individual	\$6,600	\$6,850	3.8
Average MOOP Plan Individual	\$6,408.33	\$6,568.75	2.5

Specific health plan details for 2017 are not available at this time. However, UnitedHealthcare, whose pricing and benefit combinations have never proved appealing to a large group on the exchange, has withdrawn from participating. Blue Cross Blue Shield has increased its premium rates (4.7 percent for its Essential Health Benefits base rate for the individual market), while Neighborhood Health Plan boasts a sharp decrease in rates (9.8 percent for its comparable EHB rate).⁸¹

2.7(b). Clearinghouse or Active Purchaser. When creating HealthSource RI, state officials embraced an “active purchaser” model based on the expectation that the exchange would negotiate with insurers to yield the best possible array of number and types of health plans for Rhode Islanders with each new enrollment cycle. As stated in Executive Order 11-09, the “advantages” of adopting a state exchange would include the opportunity for developing “cooperative relationships with insurers, brokers, and other business partners.” Citing the need for cost-containment and quality in insurance choices, the Executive Order gave the exchange authority for:

1. Aggregating the purchasing power of individuals and small businesses to leverage high-quality and affordable products, and payment reforms that reform health care delivery.
2. Aligning purchasing strategies with state agencies.
3. Standardizing products to provide manageable and meaningful choices.

This approach is contrary to the idea of an exchange as a mere “clearinghouse” lacking meaningful public regulation of listed insurance plans and their costs.

HealthSource RI announced plans and rates for its first Open Enrollment period in August of 2013.⁸² The agency described these market choices as “the result of HealthSource RI’s extensive negotiations with the carriers.” In preparing for the three subsequent enrollment cycles beginning in fall of 2014, 2015, and 2016, such negotiations continued to be a cornerstone of activity at the exchange as the number and features of plans have undergone adjustment. At the time of this writing, HealthSource RI has not yet announced its tableau of health plans for 2017, although only two insurance carriers will be participating due to UnitedHealthcare’s withdrawal. Rhode Island is one of several states in which UnitedHealthcare is exiting the exchange market due to financial losses, a national business strategy by the company that shows the limitations of negotiation by particular state exchange authorities.

HealthSource RI’s active purchaser role in regard to negotiating health plan benefit structures coincides with actions by the Office of Health Insurance Commissioner as the regulatory authority overseeing insurance premium rates in the state. OHIC is responsible for licensing insurers that propose to operate in

Rhode Island, as well as approving rates charged by these insurers for their products. Rate review is a very complex process. The Affordable Care Act requires intensive scrutiny of the reasonableness of proposed rate increases at or above 10 percent.⁸³ In Rhode Island, rate review is conducted for all lines of health insurance business, regardless of the amount of increase put forward by a carrier, making it a far more comprehensive process than what is prescribed by the ACA. Further, as described by former Rhode Island Health Insurance Commissioner Christopher Koller, “Deciding to enter an insurance market is a function of persuasion and politics as well as finances. State insurance commissioners generally guard those gates, and they can be friendly or foreboding to prospective applicants depending on their interpretations of regulatory standards for network adequacy, subscriber-contract compliance, and rate filings.”⁸⁴

Currently under the Affordable Care Act, a broad range of exchange behaviors is evident ranging from the very active purchasing stance of a state like California to the relatively passive stance of the federal exchange model. Lots of variation across the country is bracketed by these two endpoints.⁸⁵ In reality, the concept of “active purchasing” is a fluid one that encompasses more than a single actor’s behavior, and it is open to inflection depending on the resources and motivations of the health exchange in question. Rhode Island arguably belongs in the upper region of this spectrum if the past practices of HealthSource RI and OHIC are viewed in conjunction. This is necessary due to the consultation that has taken place between the two with respect to the appropriate role of each agency in determining products to be offered on the exchange, their certification as Qualified Health Plans, their approval under Rhode Island statute, and their rates. However, the nature and extent of active purchasing that goes on for each plan year is fluid, influenced as it is by agency administrators and the political authorities to whom they answer. One piece of legislation submitted to the Rhode Island General Assembly, although not given serious consideration to date, would expand the active purchasing role of the exchange fundamentally by using it as the vehicle for constructing a single-payer entity incorporating all private and public insurers. This proposal and its significance will receive further examination in the Summary section of this report.

2.7(c). Program Articulation. The recognition that HealthSource RI enrollees would frequently be clients of other agencies and service systems was essential to the exchange’s design and operational routines. HealthSource RI was embedded in a coordinating network of relationships with other state bureaucracies, including the Department of Human Services, Department of Health, and Office of Health Insurance Commissioner, among others, for purposes of program planning and oversight. Parallel to this emphasis on the client level has been the placement, or utilization, of personnel in a range of community organizations

who are trained to assist consumers with the process of signing up for insurance through HealthSource RI while dealing with the complications of any cross-agency eligibility issues.

The main client group of concern from this standpoint of eligibility determination consists of individuals and families newly qualifying for Medicaid benefits under the Modified Adjusted Gross Income (MAGI) criteria in the Affordable Care Act. Far from a simple income assessment, the eligibility requirements for these applicants include “technical, cooperation, and characteristic” rules set by the Rhode Island Executive Office of Human Services, not HealthSource RI.⁸⁶ The prospect of enrollees being delayed or denied because of poor articulation between the Medicaid program and the health exchange led the latter to formulate a “No Wrong Door Policy” ensuring that MAGI applicants would have both their health insurance and Medicaid eligibility issues addressed when entering any HealthSource RI portal.

The ultimate solution to this eligibility quandary, which involves potentially time-consuming verifications of information from multiple state and federal data sources, would be a grand integration of “eligibility platforms” across health and human service bureaucracies. As already noted, such an effort was initiated in Rhode Island in 2013 under the Unified Health Infrastructure Project (UHIP). More discussion of UHIP appears in Section 2.8 below on Data Systems and Reporting.

The full benefits of UHIP lie somewhere in the future. Meanwhile, HealthSource RI continues to contend with enrollment mix-ups that detract from its administrative efficiency while imposing inconvenience on some insurance subscribers. Part of the difficulty may result from underperformance by the first contracted vendor for the Contact Center. Consumer complaints, however, transcend Contact Center specifics to include problems seemingly rooted in the exchange’s computer system built with more than \$100 million in federal funding.⁸⁷ The good news is that HealthSource RI has focused managerial attention on this issue of enrollment missteps over the past eighteen months. Evidence collected by the agency now indicates marked improvements in the consumer experience for its customers.

2.7(d). States that Did Not Expand Medicaid. This section is inapplicable to Rhode Island.

2.7(e). Changes in Insurance Markets. The broad picture of HealthSource RI as a marketplace comes into view, first, with respect to the level of participation among insurance companies located in the state. When the exchange began operations in October of 2013, two carriers — Blue Cross Blue Shield and Neighborhood Health Plan — put forward plans for individuals. During the next two enrollment cycles, insurer participation rose to three with the entrance of UnitedHealthcare. Then, as noted above, UnitedHealthcare announced its withdrawal from the fourth enrollment period beginning in fall of 2016, returning the exchange to its original two private carriers.

Across the three completed enrollment cycles, noteworthy changes have occurred in market share among insurers. The overwhelming number of enrollees, 97 percent, went to Blue Cross Blue Shield in 2013-14, while Neighborhood Health Plan attracted only 3 percent. In the following year, however, Blue Cross Blue Shield and Neighborhood Health Plan split enrollees almost equally, 49 percent versus 48 percent, with UnitedHealthcare providing coverage for the remaining 3 percent. In the third enrollment cycle, Neighborhood Health Plan managed to edge out Blue Cross Blue Shield, 49 percent versus 48 percent of market share, while UnitedHealthcare maintained its distant third position with 4 percent of enrollees.

These market developments reflect Blue Cross Blue Shield's long-time dominance of the health insurance scene in Rhode Island, and its decision to quickly establish a strong presence on the exchange. It took longer for Neighborhood Health Plan to add to the number of plans it offered and to shift its position away from confining coverage to moderate- and low-income enrollees (at or below 250 percent of the Federal Poverty Level). When it did make this move, Neighborhood Health Plan came out with offerings that were cheaper than those of BCBS, and a number of enrollees shifted. In Rhode Island as elsewhere, UnitedHealthcare's involvement with the exchange has been tentative, with no pronounced commitment to the mission of health care reform that was being advanced through this vehicle of a regulated marketplace.

Low-income residents have always made up the bulk of enrollees in the HealthSource RI marketplace. In the 2015 plan year, 88 percent of customers received tax credits to make their premiums more affordable, and the same percentage was true in 2016.⁸⁸ Between 2015 and 2016, the percentage of customers qualifying for cost-sharing reductions (CSR) as well as tax credits rose from 56 percent to 61 percent. The CSR program is a tool under the Affordable Care Act for offering additional assistance to individuals between 100-250 percent of the federal poverty level who choose to enroll in a Silver plan.

To summarize, enrollment in HealthSource RI's individual market has grown consistently over three Open Enrollment periods. Within SHOP, HealthSource RI enrolled its 500th small business in June of 2015 (discussed below in Part 3). Counting employees and their family members, the number of covered subscribers exceeded 3,500. In September of 2015, new survey data showed Rhode Island's uninsured falling from about 113,000 to 50,000 since 2012, bringing the rate of uninsurance to 5 percent.⁸⁹ The impact of HealthSource RI, coupled with expansion of Medicaid, was unmistakable. When health exchange operators included an optional question on 2016 insurance applications asking when the customer was last "covered by any type of insurance," 31 percent had not had insurance within the previous year.

An unusual “experiment” in the market dynamics of health insurance exchanges took place in Rhode Island for plan year 2015.⁹⁰ Although the federal health exchange employed an automatic process for renewing enrollees signed up for coverage for 2014, HealthSource RI was in the vanguard of a small number of states that required existing customers to re-enroll for 2015. This meant returning to the exchange and shopping for a plan, even if the choice turned out to be the same as in the prior year. The Rhode Island policy was a way of encouraging customers to revisit the exchange and review all available options while taking into account any changes that might be occurring in the benefits, price, out-of-pocket costs, provider network, etc., of their current plan. HealthSource RI Executive Director Christine Ferguson wanted to heighten awareness of different insurance products and, in turn, give customers more leverage in making carriers responsive to their preferences and needs. Re-enrollment also served as an incentive to draw UnitedHealthcare onto the exchange in Year Two, since automatic continuation in Year One plans would have made it less likely for enrollees to consider any new UnitedHealthcare plans. Critics, however, cited the risk of losing enrollees who failed to complete the re-enrollment process, thereby adding to the ranks of the uninsured. In the end, more users of HealthSource RI than HealthCare.gov returned to their exchange to shop for a 2015 plan, and the majority did switch to a new health plan. However, a substantial number of HealthSource RI enrollees from 2014 did not re-enroll for 2015, as predicted, which necessitated that state officials undertake additional outreach to this group.

Evaluations of the performance and market effects of HealthSource RI differ depending on the indicators selected. Citing the high volume of sign-ups, reduction of the state’s uninsured, restrained premium increases, and increased scope of health plan benefits, including a greater focus on illness prevention and health promotion, the Obama administration has held up Rhode Island as an example worthy of commendation and emulation.⁹¹

An alternative perspective has been advanced by a research group at Providence College based on data gathered through the end of HealthSource RI’s second Open Enrollment period. This analysis gauged the success of health exchanges in “facilitating enrollment” and “increasing competitiveness” using various measures. Solely of interest were enrollments in the non-Medicaid segment of individual plans, under the premise that this methodology would capture the most direct evidence of an exchange’s impacts. The authors were intent on separating the performance of a health exchange as a market located within, but not identical with, the larger health care system. Their conclusion: “Rhode Island’s state-based marketplace earned an overall grade of B-, placing it in the top half of states in terms of overall marketplace performance. Rhode Island did well in promoting competition in

the individual insurance market: it was one of only five states to earn an A on both limiting premium growth and expanding the number of qualified health plans available in the marketplace. However, Rhode Island ranked poorly in signing up new enrollees and performed just slightly above the national average in the proportion of eligible individuals enrolled.”⁹² In a follow-up item published in the *Journal of the American Medical Association* in June of 2015, two members of the PC research team underscored the questionable performance of state-based marketplaces (SBMs) according to several indicators, including start-up costs, sign-up rates, enrollment growth, and premiums.⁹³ In regard to overall cost per health plan enrollee, the article reported that “Notably the 4 most expensive SBMs (Hawaii, the District of Columbia, Rhode Island, and Vermont) received more than \$4000 in federal grants per enrollee in 2015, whereas 8 SBMs spent less than \$2000 per enrollee.”

One potential problem with state-level comparisons as a methodology for evaluating exchange performance is that states like Rhode Island in which Medicaid has undergone expansion have a proportionately smaller number of individuals eligible to enroll in the marketplace than in nonexpansion states.⁹⁴ Also, the statistic of new enrollment gains can be a misleading indicator to the extent that it is influenced by the enrollment successes (or disappointments) of earlier years. The hypothesis here is that it becomes increasingly difficult for an exchange to enroll new customers after those most able and willing in the pool of eligibles have already signed up. With the current uninsured rate approximating 5 percent of the state’s population, HealthSource RI is unlikely to find it easy to edge closer to universality relying solely on past techniques and offerings.

2.8. Data Systems and Reporting

Health insurance is a data-driven enterprise, never more so than in a regulated marketplace devoted to presenting customers with a spectrum of well documented alternatives that must, on the one hand, satisfy federal benefit mandates and, on the other hand, respond to the population’s need for affordable coverage and its preference for flexible, convenient services. Appearing before the Committee on Finance of the U.S. Senate in February of 2013, Christine Ferguson described the importance of “new types of quality data” that would be provided to the customers of HealthSource RI to support “decisions about their health care purchases. And on a statewide basis, that information can be equally important as we look at broader health system issues.”⁹⁵ Capacity-building for Information Technology was a prime area of funding under the federal grants Rhode Island received for creating its exchange.

The attention given to collection and management of data is evident in the level of detail provided to users of HealthSource-RI.com, which makes it possible to compare premiums, tax

credits, and in-depth benefit provisions across different carriers and categories of plans. An online calculator facilitates estimation of the costs and savings of options based on a customer's age, family size, and income. Behind the scenes, this consumer-friendly interface reflects painstaking microanalysis of carrier filings in the annual process by which HealthSource RI certifies Qualified Health Plans.

HealthSource RI publishes reports at the conclusion of each Open Enrollment period profiling its customer base (including demographic and geographic characteristics), available health plan options, and the insurance choices made by consumers. Not just a valuable resource for state officials tracking exchange performance, the media have also presented digests of this technical compendium to a public audience. Latest estimates of the uninsured in Rhode Island come from a Health Information Survey commissioned by HealthSource RI that contacted approximately 5,000 households and more than 12,000 individuals in 2015.⁹⁶ The results highlighted demographic and behavioral characteristics of the uninsured, including employment status, time uninsured, and reasons for remaining uninsured, that could be instrumental in developing strategies for reducing this population.

Once it was up and running, HealthSource RI quickly partnered with other agencies in the quest to build quality data systems for improved health planning in the state. One example is HealthFacts RI, an All-Payer Claims Database, that is a joint endeavor among the Executive Office of Health and Human Services, Department of Health, Office of Health Insurance Commissioner, and HealthSource RI.⁹⁷

The Unified Health Infrastructure Project has already been noted briefly above. According to the Rhode Island Office of State Auditor, UHIP refers to the construction of a platform "to support both new and existing health insurance initiatives under the Affordable Care Act (ACA), support existing human services programs, providing hosting services for the state's health benefits exchange and integrated eligibility systems (HIX/IES), and potentially provide contracted operations of key business functions of the HIX/IES."⁹⁸ The objective is to replace outmoded state information systems with a new architectural solution aligning the functional requirements of health reform with enrollment and other administrative activities in adjacent state bureaucracies. HealthSource RI has been a main financial contributor to UHIP via its federal grant support. Four agencies, including HealthSource RI, EOHHS, Department of Human Services (DHS), and OHIC, are participating as principal collaborators although, by one count, a total of nineteen agencies and vendors have become involved in the project.

The Rhode Island Public Expenditure Council hailed UHIP as an opportunity to achieve "efficiencies related to coordination by streamlining efforts across departments."⁹⁹ In 2015, UHIP received a "Best of Web and Digital Government Achievement

Award” from the Center for Digital Government. There are claims that UHIP could eventually save Rhode Island \$40 million in state funds yearly through improved eligibility determinations and control of fraud and abuse.¹⁰⁰ However, the project has been marked by delays and cost increases, the price tag reaching \$380 million by October of 2015.¹⁰¹ The second phase of UHIP, consisting of an integrated system with many human service programs, was launched in September of 2016 and resulted in the layoff of seventy Department of Human Services workers no longer needed to serve in their current roles.¹⁰²

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchange

In Rhode Island, HealthSource RI operates the Small Business Health Options marketplace within the same administrative structure as that for individual insurance plans. One comprehensive web site, HealthSourceRI.com, provides access to Medicaid, individual insurance plans, and SHOP offerings. SHOP customers are able to compare and select small business insurance products by means of a portal separate from the individual plans. The Rhode Island Department of Health issued “Rules and Regulations Pertaining to the RI Health Benefits Exchange” (RC23-1-1-ACA) in August of 2014. Among other requirements, this document outlines how premiums will be aggregated (monthly) and how employer and employee contributions for a selected health plan will be identified. The SHOP, in accordance with these regulations, handles the collection of money and makes payments to insurers for all enrollees.

SHOP received a warm welcome in most parts of the state’s business community. According to a 2015 article published in the *Rhode Island Small Business Journal*: “The primary goals of the program are to help employers manage healthcare costs, promote a healthy workforce, and eliminate obstacles to getting healthcare coverage. Business owners consistently list employee healthcare as one of their top expenses. There is no downside to looking at the options through HealthSource RI because pricing is the same, by law, both on and off the exchange.”¹⁰³ Indeed, the leaders of HealthSource RI have worked closely with small business in promoting SHOP by forging an active relationship with groups such as The Health Initiative and The Rhode Island Small Employer Task Force.

Of particular appeal to business owners as well as workers is SHOP’s “full employee choice” feature, a distinctive design strategy offered by few other exchanges across the country. Employers selecting this option set a defined contribution for health coverage per employee. Employees, in turn, have the freedom to apply this coverage amount toward any of the twenty plus plans offered in the SHOP marketplace. More than 75 percent of HealthSource RI’s

small business customers favor the full-employee-choice mechanism.¹⁰⁴

To assist further with outreach for SHOP, HealthSource RI trains and certifies licensed insurance agents and brokers to work with small employers in purchasing coverage on the exchange. HealthSource RI does not compensate these intermediaries; rather, they receive a form of payment directly from the insurance plans according to a formal agreement put in place between insurance agents and brokers and HealthSource RI.¹⁰⁵ HealthSource RI has also assembled its own Business Engagement Team for on-site customer support “to help employers and employees find the health coverage that best fits their needs and their budget.”¹⁰⁶ Other marketing now also includes a Facebook page for employers who participate in SHOP.¹⁰⁷

Parallel to features in HealthSource RI’s individual marketplace, SHOP offers the means to compare insurance products and prices considering such factors as age of enrollee and the metal level, benefits, provider network, and out-of-pocket costs of a listed plan.¹⁰⁸ For the three Open Enrollment periods now past, SHOP gave a choice among the insurers Blue Cross Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and UnitedHealthcare. With UnitedHealthcare’s departure from both HealthSource RI’s individual and small group marketplaces for 2017, this will leave two insurers participating in SHOP.¹⁰⁹

Early SHOP enrollment was slow but promising. According to a *Providence Business News* article, 133 small businesses signed up and paid for health insurance through HealthSource RI as of March 8, 2014, increasing from 107 enrolled businesses just one month prior. The group accounted for 491 employees and 795 total lives covered. The article continued: “However, 1,132 employers have initiated HealthSource RI enrollment applications they did not complete, suggesting many more businesses may have explored getting insurance through the exchange but declined or became frustrated in the process.”¹¹⁰ Notwithstanding speculation about customer dissatisfaction, by June 1, 2014, employer enrollment in SHOP stood at 229 companies, whose 884 employees corresponded to a total of 1489 covered lives. An average of 3.9 employees enrolled per business. This figure was consistent with national data, which showed that the average number of employees enrolled per employer in SHOP was 3.7 for this year. One possible explanation is that it is the very smallest businesses benefiting from, and attracted by, the rates made available to them in SHOP.¹¹¹ As of February 20, 2016, Rhode Island’s SHOP continues to exhibit slow but steady growth, with 811 completed small business applications covering 4,075 lives. SHOP has a 93 percent renewal rate, and 86 percent of employers select the Full-Employee-Choice model.¹¹² Despite the latter’s appeal, SHOP enrollment has been somewhat disappointing in Rhode Island as elsewhere. The need exists to clarify the factors

affecting the slow take-up, including, it has been suggested, possible employer skepticism as well as resistance among insurance brokers.

Part 4 – Summary Analysis

4.1. Policy Implications

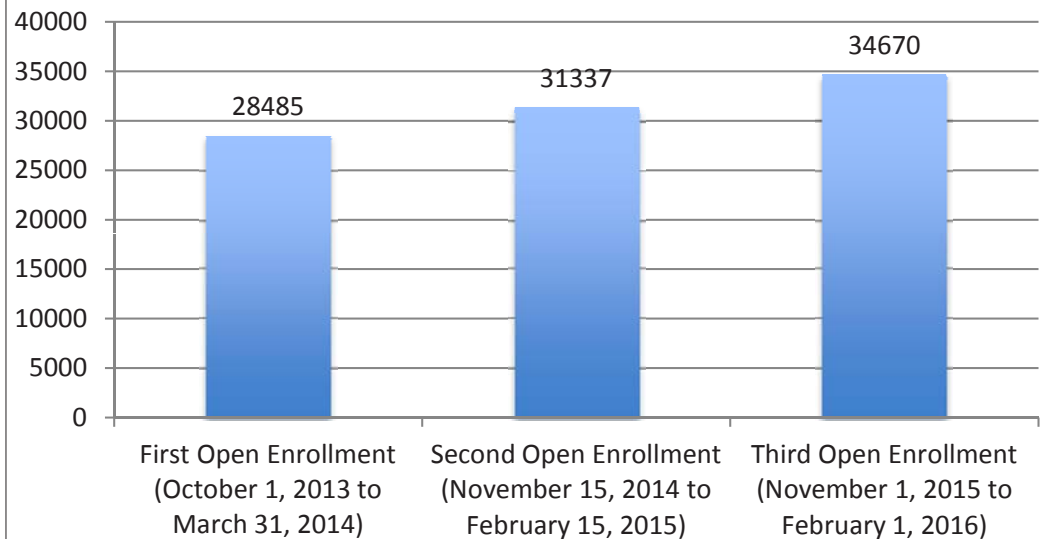
The creation of Rhode Island’s state health exchange was a real feat. As she stepped into the role of founding director in September of 2013, Christine Ferguson told a reporter: “We have a lot of work to do over the next couple of years. There’s no sure bet. This has never been done before. Never, ever.”¹¹³ And it was true. Not even the Massachusetts Connector, which helped to inspire the federal health reform law, had delved into the intricacies of Medicaid expansion and marketplace structuring on the scale expected under the Affordable Care Act.¹¹⁴

The difficulties surrounding emergence of a new public agency are both political and organizational in nature. For HealthSource RI, vacillating support in the state legislature was compounded by a lingering national debate over “Obamacare,” all of which necessitated the unusual route of Governor Chafee’s Executive Order. The controversy over abortion that flared up when the Rhode Island General Assembly first considered a health exchange proposal did not get resolved until mid 2015, when legislators enacted a law to replace the Executive Order and required participating insurers to include at least one plan with restricted abortion benefits at each metal level for which they are offering insurance coverage.¹¹⁵ At this juncture, the Christian group Alliance Defending Freedom also dropped its federal lawsuit against the state concerning the paucity of health exchange plans without expanded abortion coverage.

On the technical side, it was necessary for HealthSource RI to become quickly integrated into the state’s bureaucratic infrastructure while fashioning innovative ways of working hand-in-hand with private consumers, employers, and insurance carriers. The outreach effort was monumental, as were such tasks as computerized enrollment, coordination with Medicaid and other social welfare programs, and managing a complex flow of public subsidies, customer premium payments, and employer contributions. Multiple contracts with private vendors had to be written and supervised. The federal government’s reporting requirements were detailed and demanding.

And yet, HealthSource RI got off to a running start in late 2013. The problems that embarrassed the federal government with HealthCare.gov, as well as the snags afflicting state health exchanges in Oregon, Massachusetts, Maryland, and Hawaii, demonstrated all that could have gone wrong in the Ocean State but did not. Using data published by the federal government, Figure 3 displays the growth in sign-ups over the exchange’s first three Open Enrollments, which went from approximately 28,000

Figure 3. HealthSource RI Enrollments (Pre-Effectuated) 2013-16



to more than 34,000, for a total increase of 21.7 percent. (These figures are “pre-effectuated” counts recording individuals who enrolled in a plan but who may not have made their first premium payment yet).¹¹⁶

Leaders of HealthSource RI also set a high bar for transparency in the volume of information made

available through the agency’s web site, frequent news releases, responses to media inquiries, and updates to state officials. Over the past four years, the *Providence Journal* has published 300+ news items and opinion pieces on the exchange (according to that paper’s search engine). *The Providence Business News*, a weekly, ran about fifty items, while Rhode Island Public Radio produced 160 stories, including interviews with Christine Ferguson and Anya Rader Wallack. Local TV stations WPRI, WJAR, and ABC6 provided their own active coverage in this period, including broadcast stories as well as web posts. Aside from instances of public scandal or local natural disasters, has there ever been another bureaucratic venture in the annals of Rhode Island government attended by such widespread interest, or one in which an agency invited such regular monitoring of its management activities and performance indicators?

The winners resulting from Rhode Island’s implementation of the Affordable Care Act seem plain enough. They include those among the thousands of residents enrolled in the state’s expanded Medicaid program, or signed up for a private exchange plan, who would have been unable otherwise to obtain equivalent coverage or to access the tax credits and Cost Sharing Reductions necessary to purchase such coverage. In addition to a drop in the uninsured, there has also been a reduction of underinsurance in the state to the extent that enrollees in Medicaid and HealthSource RI have acquired insurance adhering to standards for minimum benefits and cost sharing. And, as suggested above, the very open style of administration for this program has profited any member of the general public seeking better understanding of the health policy dilemmas facing state and federal governments at this time. Or, to put it more colloquially, one might say exchange officials offered an unusual window for peering inside the sausage factory concerning this bold policy experiment.

On the negative side, Rhode Island's exchange continues to grapple with customer service issues.¹¹⁷ For an initiative centering on consumer empowerment, this problem is basic, and reports of recent progress on the matter are encouraging. Even more significant, however, is the gap between enrollment in HealthSource RI and the number of Rhode Islanders meeting eligibility criteria for its offerings. The Henry J. Kaiser Family Foundation reports that only 41 percent of the latter group is receiving coverage through the exchange, a revealing metric. (Kaiser defines the "Number of Potential Marketplace Enrollees" as including "all individuals eligible for tax credits as well as other legally-residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage."¹¹⁸) According to the 2015 Health Information Survey commissioned by HealthSource RI, nearly one-half of all uninsured in the state say that cost is "absolutely the only reason" for remaining uninsured at this time. The challenge, then, is twofold: enrolling all those eligible for Medicaid or for subsidized health plans on the exchange, and making health coverage more affordable for the remainder who fail to qualify for either alternative. How the exchange as presently constituted might help to solve this puzzle is uncertain. Nor does it help that the state must cope simultaneously with a phase-out of federal funding that made HealthSource RI's design and activation possible.

It was just this intersection of issues that ushered in a free-wheeling debate about HealthSource RI in 2014 and 2015. The opposition to HealthSource RI coalesced around a few key themes. First was that the state faced unacceptably high costs to maintain the exchange. In all, Rhode Island had received slightly more than \$150 million in federal dollars to operate HealthSource RI. That funding would be discontinued at the end of calendar year 2015. Second was that the federal health exchange offered an appealing and reliable alternative for extending the work begun by HealthSource RI. This option, while not without cost to Rhode Island, promised to be more affordable over the long run than picking up the full tab for a state exchange. Third was that, for all the credit it had received for moving tens of thousands of Rhode Island residents into Qualified Health Plans since 2013, HealthSource RI had proved to be an inefficient device, technically speaking, that exhibited sluggish growth during latest enrollment cycles. One observer making all these points was Providence College health policy specialist Robert Hackey, who wrote in the *Providence Journal* that "Operating a state-based exchange is no longer a responsible fiscal choice for Rhode Island."¹¹⁹

Those in favor of HealthSource RI had counter arguments to make. First was that only by retaining a state exchange could Rhode Island have a marketplace whose workings it controlled. Second was that HealthSource RI and its model of active purchasing, if expanded, offered a prospective approach for greater cost

containment within the state's health insurance market. Third was that HealthSource RI presented a building block for broader approaches to health reform in the state attuned not simply to the fiscal bottom line, but also other values like universal coverage, consumer choice, and rationalization of the service system.

For her part, Governor Raimondo resolved to keep HealthSource RI in place, putting forward a plan in her Fiscal Year 2016 budget to make this choice feasible. Her idea involved the institution of an "assessment fee" starting on January 1, 2016 — a tax of 4.7 percent on all individual health plans sold in the state, 1 percent on all small-group health plans — that could be flexed down the road depending on HealthSource RI's budgetary needs.¹²⁰ Rhode Island's secretary of Human Services would have authority to set the exact rates. Compared with the cost of participating in the federal health exchange, also funded by an assessment on health insurance plans, the governor's approach would collect more revenue (an estimated \$11.8 million versus \$7.1 million), although other transitional fees associated with joining HealthCare.gov would make the two figures almost equal for the coming year. The distributional impact of these assessments differed somewhat due to the state's collection of fees regardless of whether a health plan is sold on or off the exchange, with some supplementation from the state's General Fund. Despite strong opposition to her proposal from some small business operators and in public opinion polling, lawmakers adopted the governor's recommendation.¹²¹

4.2. Possible Management Changes and Their Policy Consequences

In an article entitled "The Call to Rome and Other Obstacles to State-Level Innovation," published in the *Public Administration Review* in 1987, the authors identified high turnover among the top management of innovative programs in state government as a primary factor undermining the performance and longevity of those programs.¹²² Often the reason for such turnover is the opportunities received by managers to apply their talents elsewhere due to the visibility and experience they have gained from an initiative in the spotlight. The original program suffers a loss of capacity just as critical implementing tasks must be carried out.

During its first three years, the leadership of Rhode Island's health exchange turned over twice, although the reasons were more complicated than a simple "Call to Rome." The first executive director departed due to a shift in the party controlling the governorship. And, while the second executive director did move into a position of greater responsibility based on capable performance with the exchange, this move took place within state government, not to another jurisdiction. However, HealthSource RI is an agency embedded in a dense network of relationships. Changes elsewhere in the bureaucracy also mattered, including loss of the state's Medicaid director and its Health Insurance commissioner. Disrupted leadership inevitably destabilizes an

agency's operations to the extent that the highest level of strategic planning cannot proceed while appointment of a new director is pending. Nor can a confident stance vis à vis external criticism be mounted if internal reshuffling is underway. Both of these conditions prevailed in Rhode Island as the exchange moved into its second and third Open Enrollment cycles.

High leadership turnover may have added to, but it did not create, the larger dynamic of instability clouding the future of Rhode Island's health exchange. At work are currents that have bedeviled policy makers for decades, among them a poorly coordinated health system in which uncontrolled spending crowds out other public, business, and household priorities, and a government hard-pressed to fill the gaps for those left behind by a messy assortment of market and nonmarket insurance possibilities. However, while these may remain fixed parameters of the health coverage predicament, the landscape is not entirely static. In Rhode Island, new ideas are surfacing and new service configurations are being analyzed that could reshape the environment inhabited by HealthSource RI.

One development of note is a multiyear grant called the "State Innovation Model" (SIM). Funding for this initiative, which comes from the federal Centers for Medicare and Medicaid Services, is supporting a new paradigm of "value-based care" in Rhode Island that would be tied less to the existing structure of providers and payers than to proven standards of quality and efficacy and a service package informed by input from patients and community groups. Significantly, the plan to be produced by Rhode Island participants, a group that includes high-level stakeholders from public and private sectors, will focus on alternate payment methods for government and commercial insurers. For the architects of the project, HealthSource RI has a central role to play in this process given the "regulatory levers they command."¹²³

Parallel to SIM, other voices in Rhode Island have been calling for an overhaul of health care payment arrangements to achieve meaningful cost control on the way to further coverage expansion. For example, legislation to study creation of a single-payer health care authority has been submitted to the Rhode Island General Assembly centering around the concept of a robust active purchasing model (see, e.g., "The Rhode Island Health Care Authority Act," S2533, 2014).¹²⁴ Similarly, the independent advocacy organization HealthRight recommends a cap on the growth of health spending combined with consolidating the purchasing power of all third-party payers. In this context, the active purchasing strategies of HealthSource RI take on special relevance, presuming, that is, the exchange could attain a critical mass of enrollees.¹²⁵ Others also cite HealthSource RI's relatively small size as a disadvantage in realizing greater economies of scale and enhanced market power.¹²⁶

There have always been detractors who, for reasons pragmatic or ideological, wish HealthSource RI would go away. Others

appreciate the accomplishments of the exchange and favor doing what is necessary to build on this record – even if, for some, that means transferring responsibilities to HealthCare.gov. Still other observers, who view the state’s health care trajectory as unsustainable, cast HealthSource RI as a pivotal ingredient in any potential systemic reform. This debate is far from over. Meanwhile, the backdrop is shifting as the exchange slims down to just two participating insurers and its budget drops to a fraction of sums available during the past four fiscal years. Neither development seems likely to strengthen the exchange’s regulatory and negotiating clout.

HealthSource RI will continue to serve as a fascinating bellwether of health care politics and policy in the Ocean State. The state’s decision to launch the exchange belongs to a different time, when federal resources to support health reform were plentiful and Rhode Island officials held buoyant beliefs about the capacity of a novel marketplace approach, combined with a larger Medicaid program, to fill existing coverage gaps. Since then, much has been accomplished in Rhode Island, but more remains to be done. There is better understanding of the internal operational factors and external environmental conditions likely to constrain future results by the exchange. As officials wrestle with the needs of an aging population, rising health expenditures, uneven outcomes from the insurance market, and the interplay of powerful stakeholder interests, an intriguing question lingers: How can HealthSource RI be adapted as a public tool to meet these threats and opportunities? Many possibilities must be considered, among them the elaboration of health exchange products, expanded exchange functions and target groups, and the growth of SHOP. Creative regional strategies have already been authorized under Rhode Island’s 2015 exchange law, which permits the state to explore the “1332” waiver process for innovative approaches in the way the Affordable Care Act is implemented. Often a pioneer in crafting imaginative public policy solutions, it appears that circumstances once again are summoning Rhode Island to step into this role.

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Endnotes

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