

Health Reform in Rhode Island, Part 3

Moving Forward

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Introduction

Even with implementation of Rhode Island's health benefits exchange under the Affordable Care Act (ACA), HealthSourceRI, close to 100,000 Rhode Islanders may not have adequate options unless additional provisions are made by the state. Access to affordable health care is one of the most important and personal decisions anyone can make.

Previous reports by the RI Center for Freedom & Prosperity have documented both the financial disincentives created by the ACA when it comes to purchasing insurance and identified and quantified the groups of people who are likely to remain uninsured, perhaps up to 97,000 Rhode Islanders.¹

Anticipated insurance premium hikes are expected to price many individuals out of the market, notwithstanding the subsidies available through the exchange, and other reasons exist for individuals to elect not to purchase insurance, such as lack of perceived value or concern about paying for controversial services like contraception and abortion. With taxes already at overly burdensome levels, it is critical for Rhode Island to identify and promote alternative programs that will provide many more Rhode Islanders with access to health care, without placing further burdens on taxpayers.

State officials are encouraged to seek additional remedies to address this pending shortfall. The free-market programs recommended in this report by our Center are:

- Mandate-free and mandate-lite, full-disclosure insurance policies
- Interstate insurance sales
- Health care sharing ministries
- Critical illness and accident insurance

Also included in this report are other program recommendations.

It is our Center's conclusion that it is not feasible that a government-centric, one-size-fits-all approach via the state's health benefits exchange can adequately address the needs of a highly diverse population. Only with additional patient-centric, consumer-oriented options can we move toward the goal of ensuring that more Rhode Islanders achieve health care and financial peace of mind.

Policy Options for Post-ACA Uninsured Populations

While it is difficult to know how many Rhode Islanders will remain uninsured after full implementation of the Affordable Care Act in 2016 and the health insurance exchange, that number is almost certain to be unacceptably high. The optimistic scenario offered by the Robert Wood Johnson Foundation suggests that at least 53,000 will remain uninsured.² The Congressional Budget Office suggests 66,400 uninsured Rhode Islanders, and a previous paper by the Center points to a range of between 70,500 and 97,000 uninsured after full implementation of ACA and the health benefits exchange in Rhode Island.

The large number of uninsured Rhode Islanders is likely to continue to pose significant challenges to the state in a variety of ways, such as uncompensated care provided by hospitals, poor health outcomes for residents, and substantial financial burdens on the uninsured who seek care. The Rhode Island Center for Freedom & Prosperity strongly recommends that Rhode Island's government, civic, business, health, and community leadership support and promote

policies and actions that can ensure that the remaining uninsured are able to obtain health insurance or find alternative ways of financing their health care needs.

A key feature of these proposals is that they do not require new spending or programs on the part of the government, businesses, or consumers. Some require the state to request waivers from the Secretary of Health and Human Services, while others simply require the state to permit citizens to arrange financing that many will likely find unconventional, but that may suit the needs and preferences of individual Rhode Islanders.

Mandate-Free or Mandate-Lite, Full-Disclosure Policies

One of the central features of the ACA is that it requires all health insurance policies in the individual and small-group market cover what it terms “essential health benefits” (EHBs) and specifically establishes 10 general categories of care that must be included. It also establishes minimum actuarial values for these plans. The Federal Register publishing proposed rules for the EHBs describes them as follows:

Beginning in 2014, all non-grandfathered health insurance coverage in the individual and small group markets... will be required to cover essential health benefits (EHB), which include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care, and are equal in scope to a typical employer health plan. In addition to offering EHB, these health plans will meet specific actuarial values (AVs): 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan.³

Current Rhode Island Law on Mandated Benefits

Rhode Island currently requires insurance sold in the state to cover 70 specific treatments, provider types, or standards of care. They are contained in Rhode Island’s General Laws, Chapter 27-18, available at: webserver.rilin.state.ri.us/Statutes/title27/27-18/INDEX.HTM

Key Policy Recommendation: Mandate-free or mandate-lite, full- disclosure insurance

Seek a federal waiver in 2017 (earlier if federal law is changed to allow it) to offer mandate-flexible policies with full-disclosure to consumers, and pass appropriate legislative changes to Rhode Island’s General Law Chapter 27-18.

The ten categories required to be covered are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.⁴

Rather than have the Department of Health & Human Services set further minimum requirements for policies to be sold through exchanges, ACA allows each state to select a benchmark plan among currently offered and relatively widespread policies in its market to serve as the base of what qualifies as “minimum essential coverage.” If the selected plan does not currently include one or more of the 10 EHB categories (which is the case in all or nearly all states, particularly with habilitative services⁵), beginning in 2014, it and all other plans sold in the state must add the missing benefit category.

Rhode Island has selected as its benchmark plan the Vantage Blue small group plan offered by Blue Cross and Blue Shield of Rhode Island, with benefits for pediatric dental and vision as well as habilitation services added on in order to satisfy the requirement that all 10 EHB categories be covered.⁶

By giving each state the authority to select a benchmark plan from only a few existing plans without allowing consideration of new, potentially less-costly insurance plans, the ACA forces Rhode Island to lock in its current, high-priced insurance products. This prevents legislators from reconsidering the extraordinarily high number of mandated benefits driving up the cost of health insurance in the state and requires many to purchase coverage for services they neither need nor want.

Rhode Island currently requires insurers to comply with 70 specific mandates, more than any other state.⁷ The mandates range from relatively inexpensive requirements, such as making wigs available to patients who suffer hair loss as a result of cancer treatment, to more expensive treatments like in-vitro fertilization. These mandated benefits — for all individuals, regardless of whether or not they may ever need them — can raise premiums by 10–50% in any specific state,⁸ and with more mandates than any other state, it is likely that the impact in Rhode Island is closer to 50% than 10%.

This represents a significant factor in Rhode Island’s high insurance premiums, which are estimated to be the fifth-highest in the country.⁹ For the state’s uninsured population, these mandates and subsequent higher premium costs are a barrier to purchasing insurance. Particularly for the population that earns more than 400% of the federal poverty level and therefore are ineligible for subsidies under the ACA, bringing down premium prices can lead to more Rhode Islanders’ seeing value in purchasing health insurance instead of remaining uninsured.

To reduce premiums for Rhode Island residents who purchase insurance through the individual market, the state should reexamine the tradeoffs between mandated medical benefits and increased premium costs. In particular, Rhode Island should consider allowing insurers to offer “mandate-free” insurance policies that place no requirements on insurers to offer any specific service or provider type, or at least look to offer “mandate-lite” policies that retain a few mandates that policymakers believe are truly essential for ensuring that vital health care needs are met while paring back others that are less essential.

A 2010 summary by the Robert Wood Johnson Foundation found that 13 states had authorized the

sale of mandate-lite insurance policies that allowed individuals to purchase health plans that did not include all of the benefits normally required of health insurance in their state.¹⁰ According to the report, mandate-lite plans typically reduced premiums by 5–9%. Since the 2010 report, Kansas has joined the list of states allowing mandate-lite plans to be sold to residents.¹¹

To ensure consumers are not purchasing insurance without the benefits they want, insurers would be required to disclose every mandated benefit that is not included in the policy, in plain language that includes a reference to the fact that the policy does not include all of the benefits the state believes consumers should have. This would allow individuals to decide for themselves whether they want a more expensive policy with all of the benefits otherwise mandated by the state, or a less expensive policy that has fewer benefits, and be consistent with the ideals of consumer-centric health care that puts individuals and not third-parties in charge of basic health care and health coverage decisions.

While it is probably unrealistic to expect that full-disclosure, mandate-free policies in Rhode Island would be half the price of policies that include all mandated benefits, even a 20–30% reduction could lead to substantial savings for consumers in their premiums. With an average annual individual premium in 2010 of \$4,128,¹² a 30% decline would bring average premiums down to approximately \$2,892, for saving of more than \$1,200.

Allowing the purchase of full-disclosure, mandate-free policies would require a waiver request to the Secretary of Health and Human Services in 2017, the first-year waivers will be granted under current law. The ACA specifies that, “beginning in 2017, the law will permit states to apply for a waiver for up to five

years of requirements relating to QHPs, exchanges, premium tax credits, cost-sharing subsidies, the individual mandate, and certain employer requirements.”¹³ If this waiver provision contains sufficient flexibility to allow states to permit the sale and purchase of full-disclosure, mandate-free policies, Rhode Island should pursue this option.

Interstate Insurance Sales

As in most states, Rhode Island residents are only permitted to purchase health insurance policies approved by the state. Three states — Georgia, Maine, and Wyoming — permit residents to purchase insurance plans that have been approved in other states. Because Georgia’s and Wyoming’s laws only recently went into effect and Maine’s does not do so until 2014, it is too early to draw any conclusions about whether their efforts to expand competition and provide greater choices to consumers will be successful.

But the potential for interstate sales of health insurance to lower costs and increase coverage is substantial. One study found that a national market in health insurance, in which consumers were free to purchase health insurance from any state in the union, could reduce the number of uninsured in America by approximately 8.2 million persons.¹⁴ Looking specifically at Rhode Island, the same paper estimated that nearly 33,000 currently uninsured people would gain coverage if interstate sales of health insurance were permitted.¹⁵

There are two primary reasons that interstate sales of health insurance might substantially reduce the number of uninsured. As noted above, Rhode Island has more benefit mandates than any other state, which drives up the cost of insurance. Allowing

residents to purchase insurance policies from states with fewer mandated benefits would mean lower premiums, making coverage more affordable for individuals and families, particularly those that will not receive subsidies under ACA.

In addition, Rhode Island's health insurance market is highly concentrated, with only three insurers offering plans. In the individual market, only two insurers are offering coverage in 2014 (and one of those, Neighborhood Health Plan of Rhode Island, will only accept applicants whose income is less than 250% of the federal poverty level), while only three insurers offer plans in the small-business SHOP exchange. With out-of-state insurers selling policies to Rhode Island residents, incumbent insurers will face competitive pressures to lower their rates.

One of the chief challenges to interstate sale of health insurance has been the difficulty out-of-state insurers face in assembling provider networks. One report on interstate insurance sales noted "the enormous difficulty that out of state insurers face in building a network of local providers, and insurers identified doing so as a significant barrier to entry that far surpasses concerns about a state's regulatory environment or benefit mandates."¹⁶

But this is not an insurmountable barrier, particularly in Rhode Island. Both neighboring Connecticut and Massachusetts have much more competitive insurance markets,¹⁷ and insurers in both states have provider networks already established that are within an easy drive for many Rhode Islanders.

For example, the City of Woonsocket is the sixth-largest city in Rhode Island,¹⁸ with a population of just over 41,000.¹⁹ In addition to the Landmark hospital in Woonsocket, residents have access to Milford Regional Medical Center, a full-service

Current Rhode Island Law on Interstate Insurance Sales

Chapter 27-2 of RI's General Law permits out-of-state insurers to sell policies only after getting licensed in the state and complying with all existing regulations including mandated benefits, rate submission, and filing of all forms used, and Chapter 27-18-9 specifies that policies sold by out-of-state insurers must meet all the minimum requirements for insurance sold in Rhode Island by domestic insurers.

Key Policy Recommendation: Interstate Sale of Health Insurance

Amend RI's General Law Chapters 27-2, 27-18, and others to permit the sale of health insurance policies to residents by out-of-state insurers without having to comply with the existing licensing, mandated benefits, rate filing, and other requirements imposed by law.

teaching hospital just twelve miles up the road in Milford, Massachusetts. Residents in the western part of Rhode Island are within driving distance of hospitals in New London and Putnam, Connecticut, and in the Providence region, there are hospitals in Attleboro, Fall River, and Taunton, Massachusetts.

Because many if not all of the health insurers in Connecticut and Massachusetts have provider networks to which many Rhode Islanders would have relatively easy access, the problems that insurers might face in other states in building provider networks are considerably lessened. As an additional benefit, by allowing out-of-state hospitals to compete in Rhode Island's "highly concentrated"²⁰ hospital market to a much greater extent than they currently do,²¹ competitive pressures could help to restrain hospital costs.

Because Rhode Island is relatively small in both population and size, it also should be considerably easier to establish in-state networks with local hospitals and doctors than has been the experience in places like Georgia, Maine, and Wyoming.

All of these factors suggest that the major challenges that have so far inhibited interstate sale of health insurance from becoming a reality in the two states where it is presently permitted may not exist in Rhode Island, or at least exist to a much lesser degree. Because Rhode Island's health insurance marketplace is highly concentrated, with only three insurance companies offering small- and large-group insurance and only three insurers offering individual coverage, the state should encourage competition by allowing Rhode Island residents to purchase health insurance from established insurers in neighboring states and beyond.

Health Care Sharing Ministries

For more than 30 years, hundreds of thousands of Americans have had their health care bills paid through membership in what are commonly called "health care sharing ministries." Under Biblical principles, members of these 501(c)3 nonprofit religious associations voluntarily agree to share health care expenses among themselves. Although ministries are not insurance, under ACA, members of are exempted from having to pay the tax for not having health insurance.²²

There are currently three health care sharing ministries: Samaritan Ministries, Christian Health Ministries, and Christian Care Ministry. Although new ministries could potentially be created, under the ACA, the exemption from paying the tax for not having insurance is only available to members of the three existing health care sharing ministries.

Members commit to paying monthly amounts, typically termed "shares," that will be given to other members of the ministry who have health care bills to pay, typically called "needs." Members of Christian Care Ministry and Christian Healthcare Ministries send their shares to the ministry's office for disbursement to members with needs, while Samaritan Ministries members send their shares directly to other members who have needs.

Similar to the deductibles included in most health insurance policies, health care sharing ministries expect members to pay out of pocket for expenses below a certain amount, called the "member responsibility" or a similar term. Most medical treatments are available to be shared, although each ministry does list specific exclusions. For example, Samaritan Ministries will not share medical expenses relating to abortion, alcohol or drug abuse,

injuries connected to illegal acts, routine medical expenses such as annual physicals, or mental health treatment.²³ All three ministries cover maternity expenses.²⁴

Each ministry structures member shares and responsibility slightly differently:

- **Samaritan Ministries.** Individuals over age 25 pay \$150 per month; married couples with no children pay \$300 each month; single-parent families pay \$215 per month; and two-parent families pay \$355 per month. Younger individuals and families are eligible for reduced rates of \$110, \$220, \$165, and \$305, respectively.²⁵ The first \$300 of each medical need is not eligible to be shared, unless more than three needs are shared in a year, in which case the full amount is eligible for sharing.²⁶
- **Christian Care Ministry (operating as Medi-Share).** Members choose an Annual Household Portion (AHP) that is not eligible for sharing, ranging from \$500 to \$10,000. In addition, members pay different share amounts based on age and health status. A 24-year-old individual not eligible for a discount based on health would pay \$124 per month with a \$500 AHP, while a family of four with a 42-year old as its oldest member would pay \$496 per month with a \$1,000 AHP. At an AHP of \$5,000, a healthy 24-year-old individual would pay \$62 monthly, while a healthy family with a 42-year old as its oldest member would pay \$257 each month.²⁷
- **Christian Healthcare Ministries.** Members select different Personal Responsibility levels of \$500 (Gold), \$1,000 (Silver), and \$5,000 (Bronze) and pay according to the number of people becoming members, called “units.” Regardless of family size, no family pays for

Current Rhode Island Law on Health Sharing Ministries

Rhode Island’s law is currently silent on the issue of health care sharing ministries.

Key Policy Recommendation: Health Sharing Ministries

1. Rhode Island’s legislature should pass legislation similar to the Health Care Ministries Freedom to Share Act model legislation that has been passed by other states, clarifying and ensuring that insurance regulators will not attempt to interfere with these voluntary religious associations by regulating them as insurers.

2. Require that information about health sharing ministries be included on the exchange Web site and in “leave behind” materials intended for residents who decline to obtain coverage through the exchange.

more than three units. Gold members pay \$150 per month per unit; Silver, \$85 per unit; and Bronze, \$45 per unit. A family of four at the Gold level would pay \$450 per month (3 units x \$150), while an individual selecting Bronze membership would only pay \$45 each month.²⁸

Each ministry structures its membership shares differently, but generally the prices are relatively competitive with each other.

Most importantly, costs of membership in a health sharing ministry are much lower than insurance. The following table compares the costs of joining Christian Care Ministry’s Medi-Share program with Blue Cross & Blue Shield of Rhode Island’s (BCBSRI) premiums for 2014,²⁹ based on a \$2,500 AHP for Medi-Share and a \$2,600 deductible for BCBSRI coverage.

As the table demonstrates, savings over insurance typically range from 40 to 60% when comparing Medi-Share to BCBSRI, and the savings can be

Comparison: Christian Care Ministry Medi-Share and Blue Cross & Blue Shield of Rhode Island, 2014

Age and Status	Medi-Share annual payments (\$)	BCBSRI annual premiums (\$)	Medi-Share cost as % of BCBSRI premium
24 — standard health			
<i>Individual</i>	1,272	2,568	50
<i>Couple</i>	2,544	5,136	42
<i>Family</i>	4,980	8,400	59
24 — health discount			
<i>Individual</i>	1,128	2,568	44
<i>Couple</i>	1,992	5,136	39
<i>Family</i>	3,948	8,400	47
39 — standard health			
<i>Individual</i>	2,304	3,252	71
<i>Couple</i>	3,588	6,504	55
<i>Family</i>	5,100	9,768	52
39 — health discount			
<i>Individual</i>	1,956	3,252	60
<i>Couple</i>	3,048	6,504	47
<i>Family</i>	4,116	9,768	42
54 — standard health			
<i>Individual</i>	3,420	5,496	62
<i>Couple</i>	5,220	10,992	47
<i>Family</i>	6,060	14,256	43
54 — health discount			
<i>Individual</i>	2,832	5,496	52
<i>Couple</i>	4,260	10,992	39
<i>Family</i>	4,908	14,256	34

Note: Age for families based on oldest member of household for both Medi-Share and BCBSRI.

Sources: mychristiancare.org/medi-share-pricing-tool.aspx and news.providencejournal.com/breaking-news/2013/08/20/IndivAgeRates_FINAL.pdf

even more substantial in certain circumstances if an individual or family were to join either Samaritan Ministries or Christian Healthcare Ministries.

For example, a two-child family with two 60-year old parents would pay \$4,260 annually through Samaritan Ministries with a \$900 member responsibility, while a roughly comparable policy with BCBSRI would cost \$22,224 a year, nearly an 80% savings.³⁰ A single 45-year-old would pay \$540 annually for a Bronze level membership (\$5,000 personal responsibility amount) through Christian Healthcare Ministries, a savings of 81% compared with a BCBSRI plan costing \$2,880 each year, with a \$5,000 deductible.³¹

Perhaps because of these relatively low costs, health care sharing ministries are particularly attractive to low- and modest-income individuals and families. At Samaritan Ministries, for example, half of all members have incomes below 200% of the federal poverty level.³²

Employers can help to facilitate membership in health sharing ministries. The Christian Care Ministry, which offers the Medi-Share program, makes available a “Group Share” in which employers can participate, allowing them to enroll employees directly in Medi-Share.³³ Unlike health insurance, this qualifies as taxable income regardless of whether the employer is deducting the monthly share amount from an employee’s paycheck or is paying for it as a benefit.

While membership in a health care sharing ministry may seem attractive to many, there are limits on who can join. As Christian ministries, all three organizations limit membership to practicing Christians who agree to live by specific sets of

values and limitations. Members must refrain from tobacco or illegal drug use, alcohol abuse, and sex outside of heterosexual marriage.³⁴ Each ministry also requires regular church attendance, if health permits. Christian Care Ministry requires members to be U.S. citizens or lawfully present. (The other two ministries have no such requirement.)

Due to these restrictions, employers opting to enroll employees in health care sharing ministries would need to be very careful to avoid accidentally triggering discrimination claims, but it can be done in compliance with the law.³⁵

These limitations mean some uninsured (or currently insured people interested in switching to ministries) are simply not eligible to join. While it is difficult to estimate the number of Rhode Islanders who would qualify, research on religious attitudes among Americans suggest that 41% of Rhode Islanders consider religion to be very important to them, and 30% attend religious services at least once a week.³⁶ A 2009 survey found that 78% of Rhode Islanders were members of Christian faiths, with 52.5% reporting that they were Roman Catholic and 25.5% identifying with Protestant churches.

There is little information available about the religious affiliations of the uninsured or any personal behaviors that might conflict with the eligibility requirements of any of the health sharing ministries. But assuming the religious affinities of the uninsured roughly correspond with the general population, it seems likely that up to 30%, or 37,000, of Rhode Island’s uninsured might be eligible to join health sharing ministries.

Two significant aspect of health sharing ministries should be noted:

- Two of the three ministries do not prohibit undocumented immigrants from joining. Because this population is prohibited from purchasing health insurance through exchanges and frequently has relatively modest income, health care sharing ministries may be an ideal solution for those undocumented immigrants who meet the religious and behavioral qualifications.
- Because health care sharing ministries are not insurance, they are not required to share expenses relating to controversial items such as contraceptives, abortion, and other mandates that tend to drive up premium costs. For this reason, it may provide an option to Rhode Islanders and to employers with significant objections to these services, giving them an opportunity to have health care financing available for medical needs without having to violate their consciences.

While health care sharing ministries are not the solution for every uninsured Rhode Islanders (or even a majority of them), they do represent a significant option for many and should be embraced by the state, through both public policy and civil society at large.

Critical Illness and Accident Insurance

Another option that may be attractive to Rhode Islanders unable or unwilling to purchase the comprehensive coverage mandated by the ACA are critical illness, fixed benefit, and accident insurance policies, which pay lump sums for particular diagnoses or medical events and are paid as cash directly to beneficiaries.

Current Rhode Island Law on Critical Illness and Accident Insurance

RI's statutes presently exempt critical illness and accident insurance policies from the regulations imposed on health insurers, Chapter 27-18-1.1.

Key Policy Recommendation: Critical Illness and Accident Insurance

- 1. Pass legislation and regulatory guidance creating standards and broad protections for the marketing of critical illness and accident insurance.*
- 2. Include information about critical illness, accident insurance, and similar alternative insurance policies in "leave behind" materials intended for residents who decline to obtain coverage through the exchange.*

Historically critical illness policies were not intended to replace health insurance coverage. Instead, they were developed to aid patients recovering from illnesses who experienced ongoing loss of income or significant expenses associated with their recovery, such as installation of wheelchair ramps in a home or similar items. They were introduced in the United States in the mid-1990s³⁷ after first being developed in South Africa.³⁸

Although critical illness insurance is not health insurance, it may in many instances be an adequate substitute. A fundamental purpose of health insurance is to provide funding to individuals facing medical needs. By providing a lump-sum payment to an individual upon diagnosis of a particular medical condition, critical illness policies can provide crucial funding for the uninsured in the event they face major illnesses.

Not all medical conditions and diagnoses are presently covered by critical illness policies. Originally, these insurance policies covered cancer, heart attacks, and strokes. Over time, they have expanded to cover organ transplants, kidney failure, severe burns, several other heart-related diagnoses including coronary bypass and heart valve replacement, and multiple sclerosis.³⁹

While obviously leaving out several major areas of medical care, the list of typically covered diagnoses does include heart conditions, the single largest area of medical expenditures annually.⁴⁰ Cancer, which is also covered by critical illness policies, is the third-leading medical expense annually.⁴¹

The lump sum amount to be paid in the case of a diagnosis is chosen by the covered individual. Policies generally range in amount from \$5,000 to

\$1,000,000, with higher premiums being paid for higher lump sum amounts.⁴²

Depending on the lump sum amount chosen, a critical illness policy could easily cover several of the most expensive and more common medical needs faced by patients. Nationally, the average cost for a treatment of a heart condition averaged approximately \$29,100 in 2010, while the average cancer treatment cost \$35,700.⁴³

The premiums of critical illness policies are substantially less expensive than the comprehensive health insurance mandated under the ACA. According to information available on the Web site of the American Association for Critical Illness Insurance (AACII), a 40-year old male non-smoker obtaining a policy with a \$50,000 lump-sum payout could expect a premium in the range of \$710–750 annually, while a female non-smoker of the same age could expect to pay between \$510 and \$550 annually.⁴⁴ These premiums are significantly less than the health insurance policies to be sold through the exchange, where a 40-year old whose income puts him or her at the 250% of the federal poverty level can expect to pay \$2,312 after exchange subsidies are factored in,⁴⁵ and a 50 year old with income above 400% of the federal poverty level (and therefore not eligible for any subsidies) can expect to pay more than \$3,500 for comprehensive health insurance, compared with only \$795–840 for a female non-smoker.

Younger and older individuals would see different premiums. Assurant Health cites an estimated annual premium of \$151 for a 30 year old purchasing a plan with a \$25,000 lump sum payout,⁴⁶ while AACII estimates that a 60-year old male non-smoker might pay between \$1,665 and \$1,715 annually for a \$50,000 payment.

The widespread purchase of critical illness policies by otherwise uninsured Rhode Islanders could result in considerable benefits to both those receiving funding to pay for needed medical care and health care providers that might otherwise be forced to write off the cost of medical services provided to the uninsured.

According to the American Cancer Society, approximately 6,280 Rhode Island residents will be diagnosed with cancer in 2013.⁴⁷ Although cancer is more prevalent in older persons than younger, only a slender majority of cancers are diagnosed in the 65+ population and are therefore covered by Medicare. Americans between the ages of 40 and 59 have a one in 11 chance of being diagnosed with cancer, and for those under 40, the probability of getting cancer is one in 69.⁴⁸

A closer look at cancer treatment at Rhode Island Hospital gives a better sense of how many residents under the age of 65 are diagnosed each year with cancer. In 2011, Rhode Island Hospital treated 2,133 patients with new diagnosis of cancer.⁴⁹ Of those, approximately 1,088 were under the age of 65,⁵⁰ or 49% of all cancers.

Assuming Rhode Island Hospital's profile for newly diagnosed cancer patients is similar to those of other Rhode Island facilities,⁵¹ and based on its having approximately 35% of the estimated new cancer patients each year,⁵² roughly 3,000 of Rhode Island's under-65 population are likely to be diagnosed with cancer in 2013. A substantial number of these are almost certain to be uninsured — as many as 400 persons at Rhode Island's present uninsured rate of 13.6%.

The number of uninsured after full implementation of the ACA is likely to range roughly between 6%

and 10%, depending on whether the more optimistic scenario or what this author believes to be a more realistic scenario prevails. Assuming the range is accurate and the age profile and incidence rate remain relatively stable, this would imply that between 180 and 300 uninsured Rhode Islanders might be diagnosed with cancer in 2016.

This will represent a substantial financial hardship for these patients as well as their providers. At an average cost of \$35,700,⁵³ 300 uninsured cancer patients would represent a \$10,710,000 loss to Rhode Island's hospitals if they receive uncompensated care.

The numbers for heart disease (including heart attacks) and strokes are equally troubling. A 2009 report from the Rhode Island Department of Health found that, in 2007, 121 out of every 10,000 residents were hospitalized for heart disease, and another 28 were hospitalized for stroke.⁵⁴ These numbers suggest more than 15,000 heart attacks, strokes, and other cardiovascular events requiring hospitalization each year in Rhode Island.⁵⁵

To an even greater degree than with cancer, a large number of these hospitalizations were for Medicare-enrolled citizens,⁵⁶ and because of this, the uninsured segment of Rhode Islanders suffering heart attacks, strokes, and other serious heart-related ailments requiring hospitalization is relatively small, approximately 3%.⁵⁷ This still represents a serious financial burden on both uninsured heart patients and providers, however; in 2007, a hospital stay for heart-related diagnosis averaged \$35,770.⁵⁸

If the ACA succeeds in reducing the number of uninsured in Rhode Island by roughly one-third, that would still leave approximately 300 residents of the state uninsured when a heart attack, stroke, or

other heart-related hospitalization occurs.⁵⁹ Without any means to pay medical bills of this magnitude, uncompensated care provided by Rhode Island hospitals to these patients will likely exceed \$10 million annually.⁶⁰

Critical illness insurance policies are only available for certain diagnoses, leaving significant gaps in potential funding for necessary medical care. An option to cover at least part of these gaps could be accident insurance, similar to critical illness insurance in that it pays out specific sums of money for specific medical events, but with a different structure more appropriate to funding the second-highest area of medical expenditures, injuries such as from falls, car accidents, and other traumatic events.⁶¹ In 2010, costs associated with these injuries averaged \$24,232 per event nationally,⁶² although there is substantial variation in costs, depending on the nature of the injury. For example, in 2010 the average emergency room visit in Rhode Island cost approximately \$670,⁶³ while non-surgical treatment of a broken arm could be several thousand dollars.⁶⁴

Rather than paying out a single large lump sum for an entire traumatic event, accident insurance generally provides more modest benefits based on specific events. For example, Assurant Health offers an accident insurance plan that provides \$200 for an ambulance ride, up to \$5,000 for a broken arm, and \$300 per day of a hospital stay,⁶⁵ and the schedule of benefits for an American Fidelity Assurance accident policy provides \$150 toward medical imaging, such as an MRI or x-ray, \$1,000 upon hospital admission, and \$200 per additional day in the hospital, up to \$10,000 for treatment of burns, and up to \$400 for lacerations.⁶⁶

The benefits provided by accident policies are generally not sufficient to cover all of the associated medical costs, in large part because they were not originally designed to pay medical bills. Instead, they were intended to supplement health insurance benefits and cover related, non-medical costs such as lost income or paying certain expenses during recovery from an injury.

But the benefits can help to fund a considerable portion of incurred medical costs. Per-day medical and surgical expenses in Rhode Island hospitals for inpatient stays averaged \$3,238 in 2008, with substantial variation among hospitals — from \$1,888 per day at St. Joseph's to \$4,012 per day at Women & Infants.⁶⁷ A \$1,000 hospitalization benefit would cover more than half of the charge at St. Joseph's for example, and a \$500 benefit from a Washington National policy likewise covers most of the average cost of an emergency room visit.

These accident policies are relatively inexpensive, as well. For example, a policy for a 42-year-old office worker could cost as little as \$17 per month through Assurant,⁶⁸ while a 32 year old purchasing a somewhat more generous policy from Washington National could see a monthly premium of \$27.⁶⁹

Another option, more expensive but with richer benefits, would be a fixed-benefit insurance policy. These policies most closely resemble conventional health insurance, offering benefits for a wide range of injuries and illnesses tied to a specific fee schedule. Assurant Health offers one such policy that ties payments made to patients to the Medicare fee schedule.⁷⁰

Benefits of this policy include \$1,000–3,000 per day for hospitalization related to a sickness, and \$2,000–6,000 for an injury-related hospitalization,

and both inpatient and outpatient surgery are covered at between 100 and 150% of Medicare rates.⁷¹

While these policies are more expensive compared with critical illness or accident insurance, they remain less expensive than the insurance sold on Rhode Island's exchange. Assurant estimates that a 30-year old would pay about \$67 for this policy.⁷²

One concern that is likely to be raised concerning critical illness, accident, and fixed-benefit insurance policies is that some people may purchase them believing they provide the same comprehensive benefits as the health insurance products sold through the exchange. Regulations governing the marketing of these insurance products, such as requiring a clear disclaimer that the coverage is not a "qualified" health plan under the ACA and provides limited benefits compared with health insurance purchased through an exchange, can be helpful, but care must be taken not to impose such onerous burdens on the marketing and sale of these products that insurers are discouraged from marketing their plans or consumers from purchasing them.

While critical illness, accident, and fixed-benefit insurance policies generally provide benefits that are less generous than the comprehensive coverage mandated under the ACA, they do provide significant benefits at substantial savings that can help to fund needed medical expenses for Rhode Islanders and substantially reduce uncompensated care provided by hospitals and other health care providers. With this in mind, Rhode Island should pursue policies and actions that support a dynamic marketplace for these policies.

Summary

The RI Center for Freedom & Prosperity's previous paper, *Left Behind by Health Reform in Rhode Island*, demonstrated that there is no single population of uninsured Rhode Islanders with roughly identical issues and problems in obtaining health insurance. This paper has shown there are multiple potential solutions to address these populations' health funding needs.

There is no clear way to assess which of the options in this paper will be more or less attractive to any of the populations described in the previous paper, or how many individuals and families would choose them. But the following may be helpful in considering how these options can benefit some of Rhode Island's currently uninsured or those considering dropping coverage.

- **Mandate-free or mandate-lite policies.** Many of the uninsured simply fail to see value in current offerings, in large part because of coverage for treatments they do not value that drives up the price of insurance. Older Rhode Islanders who feel they are "done" having children, for example, are unlikely to want to pay the increased premium for in-vitro fertilization, and young unmarried people are likely to feel similarly. By eliminating this one mandate for some or all Rhode Islanders, premiums would drop and be seen as a better value. Looking at the groups identified in the previous paper, the "young invincibles," "gamers/self-employed," and "exempt/premium >8% income" categories are likely to fall in the group of people who don't see value in current insurance offerings.

- **Interstate insurance sales.** Health insurance is expensive in Rhode Island, and the lack of competition certainly does little to restrain premiums. For those who believe they cannot afford insurance, even after any subsidies are included, anything that brings down insurance premiums is likely to help. As an added bonus, increased competition from medical facilities across the state borders to Connecticut and Massachusetts may help restrain pricing in Rhode Island's highly concentrated hospital market. Lower premiums are likely to be attractive to every group identified in the previous paper.
- **Health care sharing ministries.** In addition to anyone who is price conscious when it comes to how much they are willing to pay for insurance or insurance-like coverage, two groups stand out as likely to benefit from widespread promotion and awareness of health sharing ministries. The first is illegal immigrants, who in addition to receiving low-cost coverage don't have to be concerned with any potential entanglements with government programs or reporting that might otherwise be involved when purchasing standard health insurance. The second group likely to find health sharing ministries an attractive option (not identified in the previous paper) are those with significant moral objections to certain covered services, particularly contraception and abortion. By not including these objectionable services, health sharing ministries provide a way for this group to have a form of health coverage that, if not available, might lead many of them to drop coverage altogether and join the uninsured.
- **Critical illness and accident insurance.** These types of policies are ideal for any cost-conscious group, which again includes nearly everyone in

Rhode Island uninsured population. Of particular interest in these types of policies may be “young invincibles” who see little value in coverage of routine primary care, as well as those with income above 400% of federal poverty, whose premiums would exceed 8% of their income and who simply cannot afford standard health insurance.

Rhode Island should not solely focus on efforts to ensure that the remaining uninsured obtain the same levels of health insurance that other Rhode Islanders have under ACA and through their employers. The population that remains uninsured will be largely composed of those who have demonstrated by their continued behavior that do not want or cannot afford the coverage types offered under the ACA.

Instead, Rhode Island should embrace policies and promotional efforts that allow these populations to obtain alternative and unconventional sources of financing for their health care needs as described in this report, and potentially other options, as well. By doing so, Rhode Island can take a significant step toward the goal of near-universal health care.

Conclusions and Recommendations for Dealing with Post-ACA Uninsured Population

Rhode Island, like every other state, will face serious challenges in implementing the ACA. Key among these challenges will be the substantial population that remains uninsured after full implementation of the law, estimated here to be between 73,000 and 97,000 persons.

In order to address the remaining uninsured, Rhode Island should pursue policies that promote alternatives to the comprehensive health insurance products offered in the state under the ACA. Ensuring that Rhode Islanders are aware of and have access to alternatives should not solely be the responsibility of elected officials and public servants, but should also be supported by business, civic, cultural, social, and faith leaders as well as the medical provider community in the state.

In order to expand health care financing beyond those who opt for coverage from employers or through the exchange, Rhode Island should pursue and promote the following:

- The “Navigators” who assist Rhode Islanders in signing up for coverage through the exchange and in enrolling in Medicaid should be familiar with alternatives, to discuss them with those who elect not to sign up and be prepared to direct them to alternatives, such as critical illness and accident insurance policies as well as health care sharing ministries.
- The state, via its health benefits exchange Web site and marketing materials and via authorized Navigators, should develop informational materials that educate Rhode Islanders about the existence of non–health insurance options for financing medical expenses, making them available online, as part of the exchange process, and for distribution and promotion by community groups.
- Public officials and community leaders should actively promote awareness of alternatives to comprehensive health insurance for those who are unable or unwilling to purchase coverage.
- The state should launch a comprehensive review of existing laws and regulations that drive up the cost of health insurance and consider allowing mandate-free, full-disclosure insurance policies to be sold through the exchange or outside of it after obtaining waivers from the federal government.
- The state should consider allowing interstate purchase of health insurance by Rhode Islanders in order to stimulate competition, particularly by insurers currently selling insurance in Connecticut and Massachusetts.
- The state should consider “safe harbor” legislation for health care sharing ministries, such as the American Legislative Exchange Council’s “Health Care Sharing Ministry Freedom to Share Act” model legislation.
- The Office of the Health Insurance Commissioner as well as the division of Insurance Regulation at the Department of Business Regulation should actively encourage innovation in insurance products that can address health financing needs outside of the regulatory structure of the ACA, such as critical illness and accident insurance policies.
- The state should consider legislation that would allow premiums paid for critical illness and accident insurance policies, as well as member shares paid to sharing ministries, to be deductible under Rhode Island’s income tax.
- Officials should seek a federal waiver beginning in 2017 allowing subsidies that would go to exchange-eligible persons to be used by individuals and families to pay premiums for critical illness and accident insurance policies, as well as shares paid to sharing ministries.
- Rhode Island’s Congressional delegation should work to promote maximum state flexibility and consumer choice in their continued efforts to address unmet needs after implementation of the ACA, such as by permitting new health care

sharing ministries to be formed, reducing or eliminating the ACA's tax penalty for persons obtaining critical illness or accident insurance policies, and allowing the sale of mandate-free, full-disclosure health insurance coverage.

The ACA, even while expanding coverage to millions of Americans and tens of thousands of Rhode Islanders, still leaves significant gaps in the health care financing needs of a large number of people. While the policies proposed in this paper are unlikely to completely eliminate this gap, they can have a profound effect by ensuring that tens of thousands of additional Rhode Islanders who would otherwise be uninsured will have access to both traditional and non-traditional sources of funding for needed medical care.

An important element of these policies is that they require very little in the way of additional state resources, and these recommended programs do not fundamentally upset the structure of the ACA. Instead, these policies focus primarily on those

An important element of these policies is that they require very little in the way of additional state resources, and these recommended programs do not fundamentally upset the structure of the ACA.

individuals and families that will remain outside the law and ensure that their medical care financing needs can be met, as well. In doing so, the RI Center for Freedom & Prosperity believes Rhode Island can become a national model for other states, fulfilling the promise of “near-universal” health care coverage that proponents of the ACA worked so hard to achieve.

¹ Sean Parnell. RI Center for Freedom & Prosperity. “Will Rhode Islanders Purchase Insurance Under Obamacare?” June 2013: www.rifreedom.org/wp-content/uploads/RICFP-PPACA-FinancialDisincentives-061013.pdf; Sean Parnell. RI Center for Freedom & Prosperity. “Left Behind by Health Reform in Rhode Island.” August 2013: www.rifreedom.org/wp-content/uploads/RICFP-PPACA-leftbehind-080513.pdf

² Matthew Buettgens and Mark A. Hall, *Who Will Be Uninsured After Health Insurance Reform*, p. 8, Table 1, Robert Wood Johnson Foundation, March 2011: www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2011/03/who-will-be-uninsured-after-health-insurance-reform-.html

³ Federal Register, Vol. 7 Number 227, p. 70645, Government Printing Office, November 26, 2012: www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf

⁴ Ibid.

⁵ Jason Milliman, “States Still Hazy on One Major Class of Benefits,” *Politico*, June 24, 2012: www.politico.com/news/stories/0612/77765.html

⁶ Essential Health Benefits: Rhode Island's Choice Under the Affordable Care Act December 2012, p. 1, Rhode Island Health Coverage Project: www.economicprogressri.org/Portals/0/Uploads/Documents/Affordable%20Health%20Care/EHBBbackground%20FINAL.pdf

⁷ Victoria Bunce, "Health Insurance Mandates in the States 2011(Executive Summary)," p. 3, Table 1, Council for Affordable Health Insurance, February 2012: www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2011ExecSumm.pdf

⁸ "Essential Health Benefits and State Mandated Benefits—At What Cost?" p. 2, Council for Affordable Health Insurance, October 2011: www.cahi.org/cahi_contents/resources/pdf/n160IOMEssentialBenefits.pdf

⁹ "Average Per Person Monthly Premiums in the Individual Market, 2010," State Health Facts/Kaiser Family Foundation: www.statehealthfacts.org/comparemaptable.jsp?ind=976&cat=5. Direct comparison with 2014 exchange rates is not feasible; these numbers are used to illustrate the magnitude of potential savings by adopting mandate-free or mandate-lite policies.

¹⁰ "States with Limited Benefit Plans Strategies, State Coverage Initiatives" (a project of the Robert Wood Johnsons Foundation), 2010: www.statecoverage.org/coverage_strategies/limited_benefit_plans

¹¹ "Governor Brownback signs 31 bills into law Tuesday," WIBW News, April 16, 2013: www.wibwnewsnow.com/governor-brownback-signs-31-bills-into-law-tuesday/

¹² Ibid at note 8.

¹³ Hinda Chaikind et al. "Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)," p. 26, Congressional Research Service, May 4, 2010: www.ncsl.org/documents/health/privhlthins2.pdf

¹⁴ Stephen Parente, et al. "Consumer Response to a National Marketplace for Individual Health Insurance," p. 15, article accepted for publication in *Journal of Risk and Insurance*, December 2010: www.hsinetwork.com/National_Marketplace_Paper_author_2010-Dec.pdf

¹⁵ Ibid, p 32.

¹⁶ Sabrina Corlette et al. "Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage," p. 11, The Center on Health Insurance Reforms, Georgetown University Health Policy Institute, October 2012: chir.georgetown.edu/pdfs/Selling%20Health%20Insurance%20-%20fnl.pdf

¹⁷ The Connecticut Insurance Department lists seven insurers authorized to sell health insurance in the individual market and 15 selling small-group plans (www.ct.gov/cid/cwp/view.asp?q=254440 and www.ct.gov/cid/cwp/view.asp?q=254446, respectively) while Massachusetts offers at least nine insurers in the individual and small-group markets (www.mahealthconnector.org/portal/site/connector/menuitem.55b6e23ac6627f40dbef6f47d7468a0c/).

¹⁸ Information found here: <http://www.citypopulation.de/USA-RhodeIsland.html>

¹⁹ U.S. Census Bureau data, available at: <http://quickfacts.census.gov/qfd/states/44/4480780.html>

²⁰ Harvey Zimmerman, "Hospital Market Concentration and Market Share in Rhode Island," p. 7, Spectrum Research Services, Inc., report prepared for the RI Department of Health, June 26, 2009: www.health.ri.gov/publications/reports/HospitalMarketConcentrationAndShare.pdf

²¹ Ibid, p. 6. According to data covering the period 1997–2003, between 4.5 and 5% of Rhode Islanders discharged from hospitals were discharged from Massachusetts hospitals, while only 0.5% were discharged from Connecticut hospitals. In Westerly, approximately 9% of residents discharged from hospitals were treated in Connecticut, while nearly 75% of Tiverton and Little Compton used Massachusetts hospitals. Only 2% of Providence residents using hospital services were treated out of state.

²² Text of Affordable Care Act, Section 1501.

²³ *Guidelines for Health Care Sharing*, p. 27, Samaritan Ministries, July 2012: samaritanministries.org/wp-content/uploads/2012/08/201207-Guidelines1.pdf

²⁴ Ibid, p. 28. Also *Medi-Share 2.0 Guidelines*: mychristiancare.org/guidelines.aspx. Also *Christian HealthCare Ministries: Step by step guide*: www.cbnews.org/maternitystepbystep.aspx

²⁵ See: samaritanministries.org/costs/monthly/

²⁶ Ibid at note 22, p. 9.

²⁷ Calculated at: mychristiancare.org/medi-share-pricing-tool.aspx

²⁸ Available at: www.cbnews.org/participationlevels.aspx

²⁹ Medi-Share was chosen for comparison because it offers different rates based on age and health status and is therefore most similar to Blue Cross & Blue Shield of Rhode Island’s premium structure. Medi-Share costs were calculated using the online calculator available at mychristiancare.org/medi-share-pricing-tool.aspx. BCBSRI premiums are based on Blue Solutions for HSA 2600 plan, see news.providencejournal.com/breaking-news/2013/08/20/IndivAgeRates_FINAL.pdf. The \$2,500 AHP/deductible level was chosen because it is the lowest dollar figure shared by both Medi-Share and BCBSRI. Several factors make exact comparisons difficult, among them being the fact that the AHP for Medi-Share is per family while deductibles for BCBSRI are per covered individual. Additionally, BCBSRI policies cover more services than Medi-Share, and the BCBSRI plan includes 20% co-insurance after the deductible is met, while Medi-Share can cover all costs after the AHP amount is reached.

³⁰ Samaritan’s non-sharable maximum per year is \$900 per family and is compared here with the very roughly comparable BCBSRI VantageBlue Direct plan with a \$1,000 deductible.

³¹ Bronze level membership compared with BCBSRI BlueSolutions for HSA Direct 5000.

³² Phone conversation with James Lansberry, vice president at Samaritan Ministries, January 8, 2012.

³³ “Group Share for Christian Churches and Employers,” Christian Care Ministry: mychristiancare.org/groups.aspx

³⁴ Specific eligibility requirements for each ministry are available at www.cbnews.org/qualify.aspx, samaritanministries.org/wp-content/uploads/2012/08/201207-Guidelines1.pdf, and mychristiancare.org/eligibility.aspx

³⁵ Email conversation with James Lansberry, vice president of Samaritan Ministries, February 12, 2013.

³⁶ Data from *U.S. Religious Landscape Survey*, Pew Forum on Religion and Public Life: religions.pewforum.org/. Data is aggregated with Connecticut.

³⁷ Presentation by Steve Pummer, Towers Perrin to Actuaries Club of the Southwest, slide 4, November 2004: www.acsw.us/fall04/10%20Critical%20Illness.pdf

³⁸ Johan Lotter, *Part I: A Short History of a New Product*, p. 19, Society of Actuaries, *Health Section News*, December 2000.

³⁹ Policies offered by specific insurers vary, this partial listing of covered medical diagnosis was found at www.stevencohenins.ca/critical_detail.html, the Web site of a Canada-based insurance broker.

⁴⁰ Total Expenses and Percent Distribution for Selected Conditions by Type of Service: United States, 2010, Table 3, Medical Expenditure Panel Survey:
meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2010&Table=HCFY2010_CNDXP_C&_Debug=

⁴¹ Ibid.

⁴² American Association for Critical Illness Insurance, Critical Illness Insurance — Answers to the Most Frequently Asked Questions: www.criticalillnessinsuranceinfo.org/learning-center/critical-illness-insurance-information.php

⁴³ “Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States, 2010,” table 3a, Medical Expenditure Panel Survey:
meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2010&Table=HCFY2010_CNDXP_CA&_Debug=

⁴⁴ American Association for Critical Illness Insurance, Critical Illness Insurance Cost Calculator:
www.criticalillnessinsuranceinfo.org/learning-center/critical-illness-insurance-cost-calculator.php#more

⁴⁵ Expected after-subsidy cost calculated using a calculator developed by the UC Berkeley Labor Center:
laborcenter.berkeley.edu/healthpolicy/calculator/

⁴⁶ See: www.assuranthealth.com/corp/ah/HealthPlans/critical-illness-insurance.htm

⁴⁷ *Cancer Facts & Figures 2013*, p. 5, American Cancer Society:
www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-031941.pdf

⁴⁸ Ibid, p. 14.

⁴⁹ Rhode Island Hospital Cancer Program Annual Report 2012, p. 11:
www.rhodeislandhospital.org/doc/Page.asp?PageID=DOC023363

⁵⁰ Ibid. Estimate based on adding the total number of reported patients diagnosed by age from 0–59 and allocating 40% of the age group 60–69 to the under-65 age group.

⁵¹ A review of the Roger Williams Medical Center 2011 Cancer Program Annual Report shows similar age distribution, with an estimated 43% of newly diagnosed cancer cases at Roger Williams being under age 65 compared to 49% at Rhode Island Hospital. See p. 7: www.rwmc.org/documents/cancer-center/2011-Annual-Report.pdf

⁵² Based on dividing the number of new cancer diagnoses in Rhode Island in 2011 per Rhode Island Hospital Cancer Program Annual Report 2012 by the total number of estimated new cancer cases in Rhode Island in 2011, per the *Cancer Facts & Figures 2011* report by the American Cancer Society, p. 5:
www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-029771.pdf

⁵³ See Ibid at note 43.

⁵⁴ *Heart Disease and Stroke Prevention: Rhode Island State Plan 2009*, p. 4, Rhode Island Department of Health:
www.health.ri.gov/publications/plans/2009HeartDiseaseAndStrokePrevention.pdf

⁵⁵ Based on applying these rates to Rhode Island’s total population.

⁵⁶ Another 2009 report by the Rhode Island Department of Health, *The Burden of Heart Disease and Stroke: Rhode Island 2009*, found a rate of 125.1 heart disease–related hospitalizations per 10,000 residents among the 35–64 age cohort, while Rhode Islanders age 65 and older had a rate more than five times greater, at 656.5 hospitalizations per 10,000. Strokes saw a similar disparity, with the 65 and older cohort having a hospitalization rate more than six times greater than 35–64 year olds. Table 17, p. 38 at:

www.health.ri.gov/publications/burdendocuments/2009HeartDiseaseAndStroke.pdf

⁵⁷ Ibid, Figure 18, p. 39.

⁵⁸ Ibid, Table 18, p. 39.

⁵⁹ Assumes 15,000 heart-related or stroke hospitalizations annually, multiplied by 2% to reflect a one-third reduction of the 3% self-pay share of heart- and stroke-related hospitalizations in 2007, see *ibid*.

⁶⁰ Assumes 300 uninsured patients multiplied by \$35,770 average cost. Note that actual losses by hospitals are likely to be much higher due to medical inflation since 2007.

⁶¹ See *ibid* at note 40.

⁶² See *ibid* at note 43.

⁶³ *Variation in Payment for Hospital Care in Rhode Island*, p. 10, December 19, 2012, Xerox Corp. report prepared for the Rhode Island Office of Health Insurance Commissioner and the Rhode Island Executive Office of Health and Human Services:

www.ohic.ri.gov/documents/Insurers/Reports%202012%20Rhode%20Island%20Hospital%20Payment%20Study/1_2012%20Rhode%20Island%20Hospital%20Payment%20Study%20Final.pdf. Author divided total emergency room visits by total emergency room revenue.

⁶⁴ Per-event or per-procedure average charges are difficult to determine in a health system with non-transparent pricing, but a report by the Minnesota Council of Health Plans in 2005 estimated that a broken arm would cost \$2,523 to treat (donsnotes.com/services/medical.html), which has presumably increased substantially due to medical inflation.

⁶⁵ Level 2 Accident Fixed-Benefit Coverage, available through online quote obtained at <http://www.assuranthealth.com/corp/ah/HealthPlans/accident-insurance.htm>

⁶⁶ See: secure.afedirect.com/brochure/pdfs/SB-15986%28TX%29.pdf

⁶⁷ *Variations in Hospital Payment Rates by Commercial Insurers in Rhode Island*, p. 13, Office of the Health Insurance Commissioner, January 2010: www.ohic.ri.gov/documents/Insurers/Reports/2010%20Hospital%20Payment%20Report/2010%20Variations%20in%20Hospital%20Pmt%20Rates.pdf

⁶⁸ See *ibid* at note 46.

⁶⁹ Based on emailed quote from Washington National representative on 2/12/2013. The Washington General policy provides a \$1,000 benefit per day of hospitalization and \$500 per emergency room visit: www.esupplemental.com/info/accident_assure_brochure.pdf

⁷⁰ See: www.assuranthealth.com/corp/ah/HealthPlans/Fixed-Benefit-Insurance-Plan-Details.htm

⁷¹ Ibid.

⁷² Ibid.