

June 3, 2014

## STATE OFFICIALS WERE ADVISED IN 2009 THAT AN RI EXCHANGE WAS NOT VIABLE AND WOULD NOT CONTAIN COSTS

### Summary

As far back as 2009, Rhode Island state officials were advised by a commission of healthcare stakeholders, convened by Lieutenant Governor Elizabeth Roberts, that a full state-based health insurance exchange was not advisable for the Ocean State due to financial costs.

Furthermore, the primary stated goal of “cost containment” being touted by HealthSource RI officials in 2014 was specifically cited in the 2009 Issue Brief as a goal that is not achievable via a state-based exchange.<sup>1</sup> The brief, which was apparently produced in June 2009, following the release of the HealthHub project’s final report in February of that year, took lessons learned from Massachusetts’s experiment with a state-based

exchange and sought to apply them to Rhode Island’s unique health insurance market.

In broad strokes, the brief indicated that “most states are not in a financial position to establish an exchange that has all the functionality of the Massachusetts Connector” (p. 2). For Rhode Island, specifically, the concern was that a market like Rhode Island, “with only approximately 100,000 small-group covered lives, and 14,000 individual participants, an optional health insurance exchange may not generate sufficient volume to be cost effective” (p. 4).

Without regard to these findings — by all indications, without *reference* to them — state officials, including some of the same people, ignored the recommendation of their own workgroup, and moved aggressively forward with a full health benefits exchange, even to the point of doing so without legislative approval. The availability of federal funds skirted the problem of an initial investment, following the passage of President Obama’s Affordable Care Act (ACA) law in 2010, but it did nothing to address the larger challenge: ongoing operations.

With federal funds due to expire soon, Rhode Island lawmakers and citizens are now grappling with the need to finance the high cost of maintaining the HealthSource RI exchange bureaucracy — simultaneously evaluating its potential future value to the state.

As it turns out, these issues were addressed by the HealthHub RI working group, and are detailed in the brief, which was funded by the Robert Wood Johnson Foundation as part of its State Coverage Initiatives (SCI) program, and which has been reviewed by other states as part of their own

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<sup>1</sup> Documents from the HealthHub RI Planning Project are available via the Office of the Health Insurance Commissioner: [www.ohic.ri.gov/Committees\\_HealthHub%20RI.php](http://www.ohic.ri.gov/Committees_HealthHub%20RI.php). Most of the quotations contained in this analysis are drawn from a summary document available through the Faulkner Consulting Group: [www.faulknerconsultinggroup.com/fcg-wp/wp-content/uploads/2013/09/SCI\\_Issue\\_Brief-Rhode\\_Island.pdf](http://www.faulknerconsultinggroup.com/fcg-wp/wp-content/uploads/2013/09/SCI_Issue_Brief-Rhode_Island.pdf)

evaluations.<sup>2</sup> The brief's findings are entirely in keeping with the recent work and testimony of the Rhode Island Center for Freedom and Prosperity on the topic.

This analysis by the Center highlights some of the major findings of that brief and questions why Rhode Island officials made the decision to move forward with a project they had previously acknowledged could not succeed in its stated primary goal, even to the point of not being a viable fiscal investment for the state.

There is little need to interpret the findings of the brief, as its own words are clear and unequivocal in meaning.

## Background

Citing directly from the brief:

Lt. Governor Elizabeth Roberts of Rhode Island proposed legislation in 2008 to establish an exchange-like organization called "HealthHub RI." While the legislation did not pass, she proceeded to convene a public process and study, beginning in the fall of 2008, to identify and evaluate options for a future exchange in Rhode Island. Many different stakeholders participated in this public process including carriers, brokers, employers, consumers, legislators, and other interested parties. The process was staffed by the state's Office of the Health Insurance Commissioner and facilitated by

consultants familiar with the state's insurance markets and the Massachusetts Connector. (p. 1)

The brief sought to address three key issues:

1. The goals for an RI exchange
2. How to meet those goals
3. Structural options for a potential exchange

While the brief did indicate that there could be some small benefits from forming an exchange, such as increased transparency of the insurance purchase process and market-organization via a Web site to facilitate comparison shopping, it concludes that:

Given the economic situation in many states, consideration of a more narrow reform — one focused on a core set of goals with a more limited exchange infrastructure may make the most sense. (p. 6)

## WHY AN EXCHANGE WAS NOT RECOMMENDED FOR RHODE ISLAND

### Cost Containment *Not* an Appropriate Goal

During recent media appearances and in May 2014 testimony before the General Assembly House Finance Committee,<sup>3</sup> the primary defense put

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<sup>2</sup> See, for example, the materials for the February 2, 2010, meeting of the Oregon Health Policy Board. Available at: [www.oregon.gov/oha/OHPB/pages/meetings/2010/index.aspx](http://www.oregon.gov/oha/OHPB/pages/meetings/2010/index.aspx) (Accessed: 6/2/14)

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<sup>3</sup> The May 28 hearing was on H7817, which would transfer the cost and administration of operating Rhode Island's ACA exchange to the federal government. Text available here: [webservice.rilin.state.ri.us/BillText14/HouseText14/H7817.pdf](http://webservice.rilin.state.ri.us/BillText14/HouseText14/H7817.pdf)

forward by HealthSource RI officials and other supporters was the hope that an exchange under state control would provide the government leverage to bring down health care and insurance costs, especially for the business market.

The HealthHub summary brief makes clear that this really is just a hope:

The highest priority goal for HealthHub RI, as defined by stakeholders, was cost containment. Yet stakeholders agreed that implementing HealthHub RI would not, by itself, constrain the growth of health care costs in Rhode Island. (p. 2)

The brief further warned policymakers to set appropriate expectations about whether or not an exchange could or should be a vehicle to drive system affordability:

... it is important to recognize that none of the exchanges established to date have focused on this as a primary goal. In fact, there is little evidence regarding how an exchange can help with cost containment. (p. 3)

And again:

To date, exchanges have done little to constrain the growth of health care costs. They have had little role regarding product pricing ... an exchange is not a necessary or sufficient element to constrain the growth of health care costs. (p. 6)

These opinions from just a few short years ago are supported today by empirical evidence from Massachusetts's experiment with a state-based exchange, which has been in operation for over

half-a-dozen years, with costs continuing to rise.<sup>4</sup> Massachusetts remains the most expensive state in the nation to purchase insurance.<sup>5</sup>

## Low Value of Market-Organizing Functionality, Possible Market Disruption

Because the Ocean State has a small population and a very small number of insurance carriers, the brief highlighted that an exchange that would “facilitate the comparison shopping and purchase of insurance by individuals and small employers alike,” was of “less value” in Rhode Island, concluding:

In Rhode Island, this process revealed that a “full” exchange, modeled after the Massachusetts reform, was not recommended or needed to accomplish most of the goals. In fact, some key elements of the exchange concept could be implemented with minimal investment in infrastructure and disruption of the market. (p. 2)

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<sup>4</sup> Commonwealth of Massachusetts Center for Health Information and Analysis. “Massachusetts Household and Employer Insurance Surveys: Results from 2001.” January 2013. Available at: [www.mass.gov/chia/docs/r/pubs/13/mhisreport-1-29-13.pdf](http://www.mass.gov/chia/docs/r/pubs/13/mhisreport-1-29-13.pdf) (Accessed: 6/2/14)

<sup>5</sup> Cathy Schoen et al. The Commonwealth Fund. “State Trends in Premiums and Deductibles 2003-2011: Eroding Protection and Rising Costs Underscore Need for Action.” December 2012. Available at: [www.commonwealthfund.org/~media/Files/News/News%20Releases/2012/Dec/1648\\_Schoen\\_state\\_trends\\_premiums\\_deductibles\\_2003\\_2011\\_1210\\_EMBARGO.pdf](http://www.commonwealthfund.org/~media/Files/News/News%20Releases/2012/Dec/1648_Schoen_state_trends_premiums_deductibles_2003_2011_1210_EMBARGO.pdf) (Accessed: 6/2/14) See Exhibit 1 on p. 4.

Moreover:

In Rhode Island, with only three insurance carriers in the small group market, this function was deemed significantly less important than it was in Massachusetts. (p. 4)

The brief appears also to indicate that development of an exchange in Rhode Island could lead to market disruptions, such as higher costs and declining employer-sponsored coverage, by concluding that an exchange “would not achieve the primary policy goals of increased access and affordability” (p. 2).

## Cost Effectiveness

Validating the Center’s aforementioned testimony that Rhode Island does not have a large enough tax base or insurance market to sustain the high-costs of operating an exchange, the 2009 brief concluded:

... states need to think carefully about whether the infrastructure they build can be financially viable. (p. 6)

In the final report of the HealthHub RI working group, the authors specifically listed two possibilities for an exchange. The version that the report concludes is “likely large enough for financial viability” differs from HealthSource RI. It would include an individual mandate (as imposed by the ACA) and would *also* be a “full exchange” in the sense that all individual and small-group plans would pass through it.<sup>6</sup>

A similar version — an “Optional Exchange + Mandate” — describes what the state actually has now, with HealthSource RI, in which:

Employers could continue to purchase insurance in the traditional way, through their broker or directly from carriers, or they could choose to enroll through the new HealthHub model. (p. 26)

In the words of the report: “Assessment: Insufficient scale to justify investment. Do not pursue.”

It is clear that the working group did not like its own findings. In the Conclusions section, the summary brief states:

Throughout this process, some members of the stakeholder group were disappointed to learn that the development of a full exchange model, as established in Massachusetts, would not meet their primary goals for Rhode Island, increased access and affordability. (p. 6)

Yet, Rhode Island finds itself in 2014 with the state government having ignored the advice of the commission, and HealthSource RI having constructed a behemoth of an administrative bureaucracy, with 19 full-time-equivalent jobs plus call center operations and other contractors as part of an estimated annual total of \$23.4 million in projected overhead costs.

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<sup>6</sup> “HealthHub RI: Options to Consider” (p. 23) January 29, 2009. Available at: [www.ohic.ri.gov/documents/Committees/](http://www.ohic.ri.gov/documents/Committees/)

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Final%20Report%20HealthHub%20RI/1\_Health%20Hub%20Options.pdf (Accessed: 6/2/14)

## 2009 BRIEF RAISES SERIOUS QUESTIONS IN 2014

The HealthHub RI working group, final report, and summary brief resulted from a public process convened by Lt. Governor Elizabeth Roberts, utilizing the expertise of the Robert Wood Johnson Foundation State Coverage Initiatives (SCI), intended to provide “timely, experience-based information and assistance to state leaders in order

to help them move health care reform forward at the state level” (p. 7).

Following the passage of the ACA, however, Rhode Island officials ignored the information and advice of their own commission, even going so far as to bypass the will of the General Assembly, in order to forge ahead with an exchange that was advised against, which is poised to cause massive budget problems for the Ocean State, and which was born under the cloud of expectations that it would not achieve its major stated goal of cost containment.

Why?