Proposed Amendments to the Rules and Regulations
Pertaining to HealthSource RI
220-RICR-90-00-1
Economic Impact Analysis

I. Introduction

As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, a public health emergency (PHE) was determined to exist nationwide in the United States by Alex M. Azar II, Secretary of Health and Human Services on January 31, 2020.[1] This declaration has been renewed every 90 days since its inception and is currently set to expire on April 16, 2022. As an additional response to the pandemic, the "Families First Coronavirus Relief Act" was enacted in March of 2020. Included in this Act was a provision which requires states to keep most Medicaid enrollees enrolled in Medicaid coverage continuously until the end of the public health emergency was declared[2].

Over time, Rhode Island's Medicaid enrollment has grown by over 40,000 because of the continuous coverage requirement of the Families First Act. Consequently, when the continuous coverage requirement ends, either due to end of PHE, or a change to federal legislation, a challenging scenario will emerge where thousands of Rhode Islanders may find themselves ineligible for the Medicaid coverage which they have relied on without redetermination for two years or more. Nationally, the Urban Institute projected last fall that more than fifteen million Americans may lose access to Medicaid when the PHE ends[3].

In response, the Rhode Island Health Benefits Exchange ("Exchange" or "HealthSource RI") proposes to amend the Rules and Regulations Pertaining to HealthSource RI for the purposes of establishing a process by which the Exchange may automatically enroll those individuals who are no longer eligible for Medicaid coverage after the PHE ends on a monthly basis, for up to 12 months into a Qualified Health Plan (QHP), if they are so eligible. Additionally, the Exchange proposes regulatory amendments that include a mechanism by which the Exchange will pay for the cost of the first month's premium in the plan that the eligible

[1] Renewal of Determination That a Public Health Emergency Exists, https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx
[2] https://www.healthreformbeyondthebasics.org/wp-content/uploads/2021/12/PHE-MOE-Unwinding-12.21.pdf
[3] https://ccf.georgetown.edu/2021/09/20/loss-of-medicaid-after-the-phe-will-likely-exceed-15-million-estimated-by-urban

resident is automatically enrolled into. The Exchange also proposes to give potential beneficiaries of this program the ability to appeal.

Pursuant to the Administrative Procedures Act, R.I. Gen. Laws § 42-35-2.9 ("APA"), the Exchange has conducted a regulatory analysis for the proposed amendments. The Exchange used the best available information at the time of publication to estimate the benefits and costs of the proposed regulatory provisions. The following analysis examines the costs and benefits of a reasonable range of regulatory alternatives reflecting the scope of discretion provided by R.I. Gen. Laws §§ 42-157-11, 14 and R.I. Gen. Laws § 44-30-101(e)(2).

II. Analysis of Regulatory Alternatives

a. § 1.8 Application and Renewal Process

1. 1.8 (D)—Direct Transition from Medicaid to QHP following the COVID-19 Public Health Emergency

Program Eligibility

The proposed amendments to 220-RICR-90-00-1(8)(D) permit the Exchange to facilitate a direct transition from Medicaid to QHP at such time that the continuous coverage requirement ends. This direct transition would only be available to individuals who meet all the following requirements:

- are disenrolled from Medicaid due to the end of the federal continuous coverage requirement,
- are eligible for a special enrollment period under 45 CFR §155.20(d)(1),
- have been redetermined as eligible for advance premium tax credits (APTC) and cost-sharing reductions (CSR) by the Exchange, and
- has a household income, as defined in 26 CFR§1.36B-1(e), that is expected to be under 200% of the federal poverty level (FPL) at the time of redetermination.

As mentioned above, since early 2020, Medicaid Departments nationwide have been prohibited from terminating enrollment of any enrollee except in instances where an enrollee:

- has moved out of state,

- has requested to have their coverage terminated, or
- has died.

This has led to an increased level of enrollment. When the provision of the Families First Coronavirus Relief Act that requires continuous coverage ends, either due to end of PHE, or other federal legislation, RI Medicaid will then be able to resume normal operations and processes of renewal and redetermination.

Prior to the continuous coverage requirement, an average of 6,900 enrollees were terminated monthly from RI Medicaid. Typically, some of these individuals are eligible to purchase a QHP through the Exchange, while others are not. Among those who are eligible to purchase a QHP, some may be eligible for financial assistance, and some are not. In order to retain coverage, individuals must, on their own or with assistance, make any necessary application updates, enroll in a plan, and then pay for the first month of coverage. There has never been a high proportion of successful transitions from Medicaid to QHP and the transition process has long been a challenge for consumers and the Exchange.

When considering automating enrollment for this program, the risk must be considered that without action, thousands of Rhode Islanders previously eligible for Medicaid may become uninsured when redeterminations resume. As described below, the program design serves to simplify their transition between coverage, mitigate risks to the enrollees by creating opportunity for changes or cancellation to be made, and limiting the program to enrollees with household income below 200% FPL[4] to target the program to those that need it most and to make the most cost-effective use of federal subsidy increases currently available.

The Exchange also considered increasing the income eligibility limit for this program. Financial assistance for coverage purchased through the Exchange exists on a sliding scale and households with lower income levels are eligible for the most assistance and households with higher income levels are eligible to receive less assistance. As a result, maximum out-of-pocket[5] expenses and premium costs for consumers are higher at higher income levels. Capping this

[4] See

program at 200% FPL leverages the maximum cost-sharing reduction[6] and tax credit assistance to keep coverage affordable for consumers and administrative costs lower for the State.

Modifying this program to increase the income eligibility limit above 200% FPL would also increase costs due to the decrease in premium subsidies for Rhode Islanders above that threshold. That alternative would be more expensive both for consumers and for the State to operationalize. Increased administrative costs would diminish the number of Rhode Islanders the State is able to automatically transition from Medicaid to QHP. For consumers with incomes above 200% FPL, not only are monthly premiums more expensive, but cost-sharing reductions available to them decrease significantly above 200% FPL and end altogether at 250% FPL. Without cost-sharing reductions, silver level plans are cost prohibitive to consumers and would therefore make a poor choice for automatic enrollment. As a result, a higher income eligibility threshold would require additional complexity in plan assignment to better suit the needs of the consumer. As a result of these considerations, choosing an auto-enrollment plan for customers with income over 200% FPL therefore becomes infeasible.

Auto Assignment

If an individual is determined eligible for this program, the Exchange would use the information available in the Integrated Eligibility System (IES) to authorize APTCs on behalf of the tax filer and enroll the individual(s) in a silver plan available through the Exchange. This plan selection will maximize the financial assistance available to enrollees with household income is below 200% FPL. Only silver plans have CSR variants that tie lower household income to lower out-of-pocket costs.

For enrollees with incomes between 100 and 150% FPL, they will receive the maximum APTC and CSR available to assist in covering the cost of coverage. APTC lowers an individual's monthly premium while CSR lowers the cost a consumer must bear out-of-pocket at times of

[6] A federally funded discount that lowers the amount consumers have to pay for deductibles, copayments, and coinsurance. CSR plans are only available in the silver metal level and are offered in addition to tax credits which lower the cost of monthly premiums.

service, or for their deductible[7]. In this income bracket, for the duration of federal subsidy increases[8] enrollees will have $0 deductible and a monthly premium of less than $1.

For enrollees with incomes between 150% and 200% FPL, they will also receive APTC and CSR assistance to cover costs of coverage. In this income bracket, for the duration of the federal subsidy increases, enrollees will have an $1,100 individual and $2,200 family deductible and a monthly premium between $1 and $50 per month, as well as assistance towards coverage of out-of-pocket expenses.

When considering alternative options for the selection of the auto-assignment plan, the higher cost of non-silver plans outweighed other potential benefits for individuals and families with household income less than 200% FPL. See table below for a comparison of what options might look like for a single Rhode Island consumer who is 43 years old and earns $20,000 annually (155% FPL):

Metal Level	Monthly Premium (w/out APTC)	Monthly Premium (w/ max. APTC)	Annual Maximum Out of Pocket	Annual Deductible
Bronze	$563 - 707	$0.12 - 2.64	$6,900 - 8,550	$6,300 - 6,825
Silver	$799 - 1,121	$2.40 - 278	$2,500 - 2,800	$150 - 1,100
Gold	$818 - 1,220	$0.33 - 377	$3,900 - 8,000	$1,250 – 2,500
Platinum	$1,469	$626	$1,800	$750

Compared to alternatives, the selection of a silver plan for auto-enrollment ensures that enrollees will receive the most financial assistance available to facilitate their continued coverage beyond the first month of the program. For enrollees who would prefer a different plan than the one selected, there is a special enrollment period (SEP) that lasts sixty days from the date their Medicaid coverage ends and allows them to select a different plan if they so choose. An individual eligible for automatic enrollment may also elect to opt out of automatic enrollment for up to 60 days after the last day the individual had coverage under his or her previous Medicaid

[8] Currently set to end on December 31, 2022.

[7] The deductible is the amount you must pay out-of-pocket for certain health care services before your insurance plan begins to pay. The deductible amount is in addition to your monthly premium. Services subject to the deductible vary by plan and may include doctor visits and hospital stays, as well as prescription medications.

managed care plan. If an individual elects to opt out during this 60-day period, the individual's QHP enrollment will be cancelled.

Coverage Effectuation

The auto-enrollment and auto-assignment program is designed to include making payment on behalf of the enrollee for the first month's premium cost, which effectuates the health insurance coverage. This design ensures that there will be no gap in coverage for eligible enrollees. It does create some risk on the consumer, in the instance they do not need or want health insurance coverage. To mitigate this, the consumer will be able to cancel the coverage or change plans for up to 60 days after the last day the consumer had coverage under his or her previous Medicaid managed care plan. The consumer may also elect to update missing information and be reevaluated for Medicaid eligibility if needed.

An alternative to making this payment on a consumer's behalf would be to require individuals to take action to effectuate their coverage. This creates the risk that they do not act and find themselves uninsured.[9] The process of Medicaid renewal or redetermination after two years of not being required to do so may mean that consumers could be confused or miss deadlines in the process. Without HSRI making the first payment, significantly higher numbers of Rhode Islanders would have short or long-term periods without insurance.

This design allows consumers to remain covered for an additional month without cost to them, and the Exchange will provide opportunity for the consumer to change their enrollment for the duration of the sixty days following enrollment. Their coverage in the silver plan for auto-enrollment will begin on the first day of the month in which their Medicaid coverage ends, ensuring continued access to health coverage.

Noticing

All enrollees will receive notification of their enrollment in the program at multiple instances. Prior to the start of their coverage, they will receive a combined notice of benefit determination and termination of their Medicaid coverage. This notice will inform the enrolled of the effective dates of their Medicaid termination and their QHP enrollment. Additionally, it will

[9] *See* Adrianna McIntyre & Mark Shepard, *Automatic Insurance Policies – Important Tools for Preventing Coverage Loss*, New Engl. J. Med., 386;5 at 408, February 2022, https://www.jstor.org/stable/27000409, (explaining that administrative burdens and complexity associated with transitioning from Medicaid to QHP substantially hinder consumers' ability to secure and maintain health coverage, and proposes automatic enrollment as a potential solution).

contain their determination of eligibility for APTC and CSR and information about how to choose a different plan or opt-out of the automatic enrollment program if needed.

Subsequently, an enrollment notice will also be received including the enrollees plan details, costs, as well as what next steps they may need to take. For example, instruction on how to change plans, or cancel coverage if needed. Additionally, information about how to log in to their customer portal account to access more information.

Alternate Income Verification Process

The Exchange will, on a limited basis, modify its verification process for annual household income under 45 C.F.R. § 155.320 by using data available to the Exchange from the State Wage Information Collection Agency instead of the individual's application attestation regarding projected annual household income. This alternate income verification process will be available if:

1. the individual did not complete the Medicaid renewal form required by 42 CFR §§ 435.916 and 457.343 in the timeframe required by the Rhode Island Medicaid agency;
2. the Exchange determines that the individual's application attestation regarding annual household income for the applicable Benefit Year is not reasonably compatible with the data available to the Exchange from the State Wage Information Collection Agency;
3. the data available to the Exchange from the State Wage Information Collection Agency indicates that the individual's annual household income is expected to be greater than or equal to 100% FPL for the applicable Benefit Year; and
4. the individual otherwise meets the eligibility requirements specified in § 1.8(D)(1) of this Part.

The Exchange has obtained approval from the U.S. Department of Health and Human Services (HHS) to modify its Blueprint in order to institute an alternate verification process. This alternate verification process is consistent with 45 CFR § 155.320(a)(2), which requires an Exchange to verify income information in accordance with that section unless HHS approves a modification to its Blueprint under 45 CFR § 155.315(h). HHS may approve a modification to an

Exchange's Blueprint under 45 CFR § 155.315(h) if it finds that the alternate verification processes would:

- reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay;
- that it would not undermine coordination with Medicaid and CHIP; and
- that applicable requirements with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.

Modifying the income verification process, as set forth above, meets the standards for HHS approval in a number of important ways. Self-attested income for people being terminated from Medicaid is likely to be outdated since the Program has paused redeterminations, including income verifications, pending the expiration of the COVID-19 PHE. For this reason, inconsistent income information from an external data source is expected to be one of the top reasons for Medicaid terminations. External data source information is therefore likely to be more recent than attested income for those leaving Medicaid and using the external source will increase accuracy in APTC calculation. This will also permit the Exchange and Medicaid programs to take a coordinated approach to these eligibility determinations, as they will be using the same external data source. This will result in a better customer experience. For example, Medicaid using external data sources and the Exchange using attestation would lead to inconsistent and confusing results, such as denial of both Medicaid and APTC, but use of the same source will likely avoid such a result.

This approach will also reduce administrative costs and burdens by increasing the Exchange's ability to automatically enroll customers, which in turn will minimize delays and improve access to coverage for Rhode Islanders. It will also reduce inflated APTC eligibility results, thereby reducing the occurrence of tax credit reconciliation. Finally, HSRI will maintain security and privacy standards for use of the information.

III. Determinations

Upon review of all the costs and benefits, the Exchange has determined that the benefits of the proposed rule justify the costs of the proposed rule. Further, the proposed rule will achieve

the objectives of the authorizing statutes in a more cost-effective manner, or with greater benefits, than other regulatory alternatives.

IV. Supporting Documentation

- Nour Kattih, et al., *The Power of Suggestion: Automatic Enrollment and Employee Health Insurance Coverage Take-Up Rates*, Journal of Insurance Issues, 44;1 at 90–107, Spring 2021, https://www.jstor.org/stable/27000409 .

- Matthew Buettgens & Andrew Green, *What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?*, Urban Institute, September 2021, https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf.

- Adrianna McIntyre & Mark Shepard, *Automatic Insurance Policies – Important Tools for Preventing Coverage Loss*, New Engl. J. Med., 386;5 at 408, February 2022, https://www.jstor.org/stable/27000409 .

- Table of Federal Poverty Level Percentages Matched to Income in Dollars:

2021 Federal Poverty Level *(for use for plan coverage year 2022 QHP eligibility)*							
Household/ Family Size	***100%***	***150%***	***200%***	***250%***	***300%***	***350%***	***400%***
1	$12,880	$19,320	$25,760	$32,200	$38,640	$45,080	$51,520
2	$17,420	$26,130	$34,840	$43,550	$52,260	$60,970	$69,680
3	$21,960	$32,940	$43,920	$54,900	$65,880	$76,860	$87,840
4	$26,500	$39,750	$53,000	$66,250	$79,500	$92,750	$106,000
5	$31,040	$46,560	$62,080	$77,600	$93,120	$108,640	$124,160
6	$35,580	$53,370	$71,160	$88,950	$106,740	$124,530	$142,320
7	$40,120	$60,180	$80,240	$100,300	$120,360	$140,420	$160,480
8	$44,660	$66,990	$89,320	$111,650	$133,980	$156,310	$178,640
Add for each additional person	$4,540	$6,810	$9,080	$11,350	$13,620	$15,890	$18,160