Rhode Island's

RIte Share Premium Assistance Program:

ESTIMATED SAVINGS

State Fiscal Year 2005

Revised January 2006

RI Department of Human Services
Center for Child and Family Health
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RIte Share Premium Assistance Program: ESTIMATED SAVINGS (SFY 2005)

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1 .Overview of RIte Care and RIte Share

RIte Care is the State of Rhode Island's managed health care program for families on Medicaid, uninsured families with incomes up to 185 percent of the Federal poverty level (FPL), and pregnant women and children under age 19 from families with incomes up to 250 percent of the FPL. Eligible individuals are enrolled in a State-licensed health maintenance organization (HMO) or another type of State-certified plan that meets explicit State requirements, collectively *Health Plans* that are paid a monthly capitation rate for providing or arranging for health services for enrollees. Implemented in August 1994, RIte Care has the following general goals:

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

RIte Share is the State of Rhode Island's premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI). RIte Share was implemented in February 2001 by signing up participating employers on a voluntary basis. Effective January 1, 2002, enrollment in RIte Share became mandatory for individuals, although the Department of Human Services (DHS) began transitioning RIte Care enrollees with access to ESI to RIte Share in April 2001. Under RIte Share, DHS pays all or a part of an eligible family's monthly premium, based upon income and family size, for an employer's DHS-approved ESI. RIte Share provides coverage of all Medicaid benefits by providing enrollees with a Medicaid card as "secondary coverage" to ESI to cover benefits not covered by ESI, ("wrap-around coverage"), as well as for co-payments and deductibles.

The goal of RIte Share is to support families in their efforts to obtain or maintain ESI. Enrollment of both employees and employers in RIte Share has continued to grow. As of January 2002, 117 employers were approved for participation in RIte Share. As of beginning of State Fiscal Year (SFY) 2005, 1,036 employers were approved for participation in RIte Share.

At the time RIte Share became mandatory, DHS estimated that there were 7,000 employees, employed by 4,500 companies, who were eligible to be transitioned from

RIte Care to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition a RIte Care member to RIte Share, employers provide DHS with information about their health insurance plan and employee contributions. Changing trends in commercial health insurance present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in cost sharing at the point of service. An employer can significantly mitigate premium rate increases by increasing deductibles, coinsurance, and copays at the point of service. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent.

2. Enrollment in RIte Share

Figure 1 shows the incremental gains in enrollment in RIte Share through December 31, 2004. There were 5,876 individuals enrolled in RIte Share as of December 31, 2004, with another 80 in the process of being enrolled in RIte Share. The figure also shows that RIte Share is having its intended effect of stabilizing RIte Care enrollment, while increasing RIte Share enrollment.

Figure 1

RIte Care/RIte Share Enrollment Update for December 31, 2004

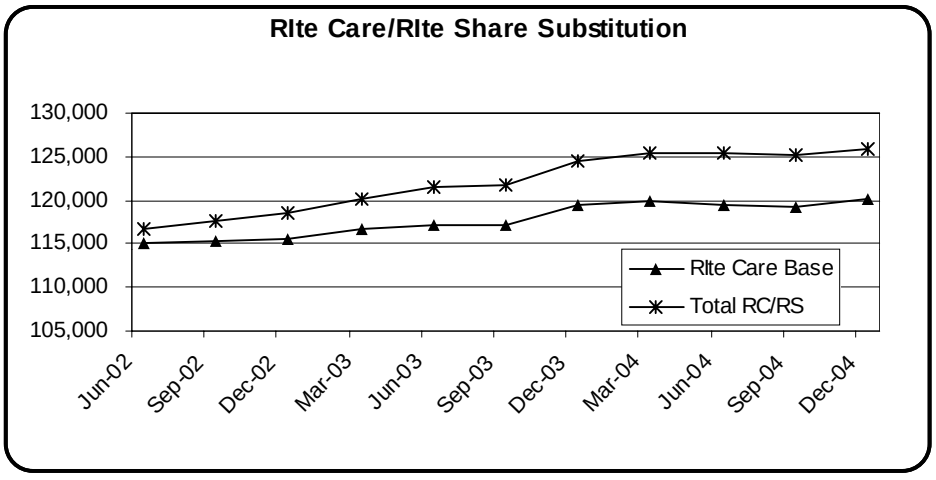


Table 1 provides some more detail on RIte Care and RIte Share enrollment by time period than does Figure 1.

Table 1

RIte Care and RIte Share Enrollment

Enrollment	RIte Care			RIte Share	Total
	Foster Care	All Other	Overall		
As of 12/31/01	1,899	115,286	117,185	111	117,296
As of 3/31/02	1,961	115,508	117,469	409	117,878
As of 6/30/02	1,983	115,041	117,024	1,596	118,620
As of 9/30/02	1,906	115,237	117,173	2,304	119,477
As of 11/30/02	1,983	115,495	117,478	2,450	119,928
As of 12/31/02	1,981	115,526	117,507	2,905	120,412
As of 3/31/03	2,138	116,640	118,778	3,511	122,289
As of 7/31/03	2,039	117,218	119,257	4,268	123,525
As of 9/30/03	1,959	117,154	119,113	4,701	123,814
As of 12/31/03	2,047	119,479	121,526	5,006	126,532
As of 3/31/04	2,029	119,986	122,015	5,432	127,447
As of 6/30/04	2,102	119,279	121,381	5,899	127,280
As of 9/30/04	2,102	119,294	121,396	5,873	127,269
As of 12/31/04	2,158	120,049	122,207	5,876	128,083

3. Cost-Sharing Under RIte Share

To discourage *crowd-out* (i.e., substituting public coverage for ESI), the State is using a combination of mandatory enrollment in RIte Share and cost-sharing. Since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of their health insurance coverage if their income is above 150 percent of the FPL (e.g., $24,135 for a family of three as of January 1, 2005). In November 2001, families received two letters and an official notice about the change. The first monthly bills were sent in December 2001, requiring payment by January 1, 2002. Rhode Island was one of four States increasing enrollee cost-sharing in 2002[1].

The required monthly family cost-share by income level is shown in Table 2[2], comparing the original 2001 cost-share amounts to those in effect since August 1, 2002. These cost-share increases were a result of a State law mandating that cost-sharing be raised.

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

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

Table 2

RIte Care and RIte Share Monthly Family Premiums

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

Monthly cost-sharing is collected in two ways:

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

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

Only about 10 percent of all RIte Care/RIte Share families have incomes above 150 percent of the FPL and are therefore subject to cost-sharing. Table 3 shows the number of families and individuals, by income level, active in cost-sharing as of December 31, 2004. There were 5,409 RIte Care/RIte Share families (13,611 individuals) active in cost-sharing at the end of December 2004. There were 17,060 RIte Care/RIte Share families *ever* active in cost-sharing through December 2004.

Table 3

RIte Care/ RIte Share Families and Individuals Active in Cost-Sharing as of December 31, 2004

Income Level	Families	Adults	Children	Total Individuals
150-185% of FPL	3,427	4,436	5,744	10,180
185-200% of FPL	657	30	1,128	1,158
200-250% of FPL	1,325	86	2,187	2,273
Total	**5,409**	**4,552**	**9,059**	**13,611**

4. RIte Share Has Saved Money

Because RIte Share supports people's ability to obtain or maintain ESI, the program has the potential to save both State and Federal funds that might have been used to provide coverage entirely through RIte Care. This reports savings estimates for RIte Share for State Fiscal Year (SFY) 2002, SFY 2003, SFY 2004, and the first eight months of SFY 2005. It also projects savings for SFY 2005. The State's fiscal year is from July 1st to June 30th of any given year.

4.1 Estimated Savings Methodology

The formula for estimating RIte Share gross savings is as follows:

Gross RIte Share Savings = RCEA – RSE

Where,

RCEA = RIte Care Expenditures Avoided

RSE = RIte Share Expenditures

There are four components to the RIte Care Expenditures Avoided (RCEA):

- **RIte Care Capitation** – This includes the monthly capitation payments to RIte Care Health Plans for in-plan services, monthly SOBRA payments[3] to the Health Plans, and neonatal intensive care unit (NICU) payments[4] that the State pays directly to Women's & Infants Hospital.

- **Risk Share –** DHS has entered into risk-share arrangements with all RIte Care-participating Health Plans. The purpose of these arrangements is to assure RIte Care-eligible individuals have a choice of Health Plans in which to enroll. Under the risk-sharing methodology, risk is shared according to whether the actual Medical Loss Ratio[5] in any quarter is within agreed-upon ranges or "risk corridors."

[3] The State pays a fixed dollar amount for each delivery. This amount includes both the hospital and physician costs (including the costs of prenatal care).

[4] When the *RIte Care Health Plan Contracts* were renegotiated in July 1998, Health Plans were given the option of DHS assuming the risk of NICU services rendered at Women's & Infants Hospital versus the Health Plans retaining the risk for these services. This was done because of the historic, relatively high cost for these services for RIte Care-eligible individuals. All Health Plans elected this option.

[5] Medical Loss Ratio means Medical Expenses divided by Premium.

- **Stop-Loss** – Some services have been covered by the Health Plans on a partial-risk basis from the beginning. Through December 31, 2004, transplants (where Health Plans must cover all costs up to the actual transplant of a bodily organ), Early Intervention (EI, where Health Plans had to cover the first $3,000 in benefits), mental health care (where Health Plans had to cover the first 30 days of inpatient care and the first 30 outpatient visits), substance abuse treatment (where Health Plans had to cover the first 30 days of inpatient rehabilitation and the first 30 outpatient visits), and nursing home care (where Health Plans must cover the first 30 days of care) were services operating under RIte Care on a stop-loss basis. Effective January 1, 2005, only transplants and nursing home care are subject to stop-loss provisions.

- **Transition/Supplemental Payments to Community Health Centers (CHCs)** – When RIte Care began in August 1994, the State had in place a system for making payments to CHCs to ease the *transition* from cost-based reimbursement by the State to fee-based reimbursement from the Health Plans. When the Special Terms and Conditions for the RIte Care waiver were revised on July 29, 2002, the "transition" payments were renamed "supplemental payments", which reflected these payments as the State's approach to the minimum Medicaid per visit reimbursement for CHCs using the Prospective Payment System methodology required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA). Each CHC is paid an interim payment each month, which is an estimated payment per month for each RIte Care member who selects a CHC as their primary care provider. At year-end, the state makes a "settle-up" payment to costs for each CHC in accordance with PPS methodology. Payments are made by the State through the Rhode Island Community Health Center Association[6].

The RIte Share enrollee's portion of the monthly premium cost described above (i.e., cost-share) is subtracted from cost of RIte Care, because these are also public expenditures *avoided*.

[6] In the future, payments will be made directly to the CHCs under a prospective payment system where payments will be reconciled to actual costs annually.

There are two components to RIte Share Expenditures (RSE):

- **Premium Subsidies** – As described earlier, families with incomes in excess of 150 percent of the FPL are required to pay a portion of the employee share of the monthly premium cost for ESI. The State pays the remainder of the employee share, which represents the *premium subsidy*.

- **Supplementary Benefits** – Under RIte Share, the State also pays for any co-payments, deductibles, and services exceeding benefit maximum under ESI. These costs are the *Supplementary Benefits*[7].

Net RIte Share State Savings is Gross RIte Share **State-Level** Savings minus **State-Level Administrative Expenses**.

4.2 Estimated Savings

Table 4 shows RIte Share estimated savings for SFY 2002, SFY 2003, SFY 2004, and SFY 2005 through February 28, 2005, as well as projected savings for SFY 2005.[8] As the table shows, both gross and net RIte Share savings have been increasing over time. There have been aggregate Gross RIte Share Savings of $12,250,449 since RIte Share began, through February 2005. It is expected that aggregate Gross RIte Share Savings will exceed $14 million by the time SFY 2005 expenditures are complete. Aggregate Net RIte Share Savings, through February 2005, have been $2,612,931. It is expected that that aggregate Net RIte Share Savings will exceed $3 million by the time SFY 2005 expenditures are complete.

It should be noted that the reason the RSE component Supplementary Benefits is much less in SFY 2005 than in SFY 2004 is due to claims lag, or the *completion factor*. Claims may be made within 12 months of the date of service; so, it will be some time before this component is *complete.*

[7] It should be noted that under both RIte Care and RIte Share there are out-of-plan benefits that are paid for apart from any other payments. For RIte Share, these are called "wraparound" services that represent benefits that the Rhode Island Medicaid program covers, but that ESI coverage does not. The costs of these "wraparound" services under RIte Share assumed to be equivalent to what the costs would have been under RIte Care and are, therefore, not included in the present analysis.

[8] It should be noted that prior-year estimates have changed from the August 2004 report. Please see End Notes for an explanation of changes.

Table 4

RIte Share Gross and Net Savings

	SFY 2002	SFY2003	SFY 2004	SFY 2005 through 2-28-05 (8 months)	SFY 2005 Projected
(1) RIte Care Capitation	$781,998	$5,266,585	$9,581,775	$7,913,693	$11,870,540
(2) Risk Share	$38,993	$293,811	$898,312	$562,103	$843,155
(3) Stop-Loss	$5,546	$21,472	$102,699	$74,640	$111,960
(4) CHC Transition Payments	$19,487	$143,148	$256,143	$262,161	$393,242
(5) Subtotal (1+2+3+4)	$846,024	$5,725,016	$10,838,929	$8,812,597	$13,218,896
(6) Cost-Share Paid	$ 0	$199,845	$318,148	$238,258	$357,387
Total RIte Care Benefit Expenditures Avoided (5-6)	**$846,024**	**$5,525,171**	**$10,520,781**	**$8,574,339**	**$12,861,509**
RITE SHARE EXPENDITURES					
(1) Premium Subsidies	$406,453	$2,366,504	$4,641,058	$3,578,139	$5,367,209
(2) Supplementary Benefits	$14,870	$340,048	$1,055,245	$813,549	$1,220,324
Total RIte Share Benefit Expenditures	**$421,323**	**$2,706,552**	**$5,696,303**	**$4,391,688**	**$6,587,532**
RITE SHARE SAVINGS					
(1) Federal-Level Savings	$260,711	$1,780,426	$3,136,886	$2,675,694	$ 4,013,541
(2) State-Level Savings	$163,990	$1,038,193	$1,687,592	$1,506,957	$2,260,436
(3) RIte Share Benefit Savings (RC Expenditures Avoided minus RIte Share Expenditures)	**$424,701**	**$2,818,619**	**$4,824,478**	**$4,182,651**	**$ 6,273,977**
(4) State-Funded RIte Share Administrative Expenses	$332,270	$507,796	$538,968	$404,767	$607,151
(5) Total (State and Federal-Funded) RIte Share Administrative Expenses	$664,540	$1,015,592	$1,077,936	$809,534	$1,214,301
(6) State-Level RIte Share Savings, net of RS admin costs (2-4)	**$(168,280)**	**$530,397**	**$1,148,624**	**$1,102,190**	**$1,653,285**
(7) Public (State and Federal) RIte Share Savings, net of RS admin costs (3-5)	$(239,839)	$ 1,803,027	$ 3,746,542	$ 3,373,117	$ 5,059,676

Table 5 shows the calculations on a per member per month (pmpm) basis. Aggregate Gross RIte Share Savings, through February 2005, have averaged $82.35 pmpm. Aggregate Net RIte Share Savings pmpm have averaged $19.25 pmpm from SFY 2002 through February 2005.

Table 5

Estimated RIte Share Savings on a PMPM Basis

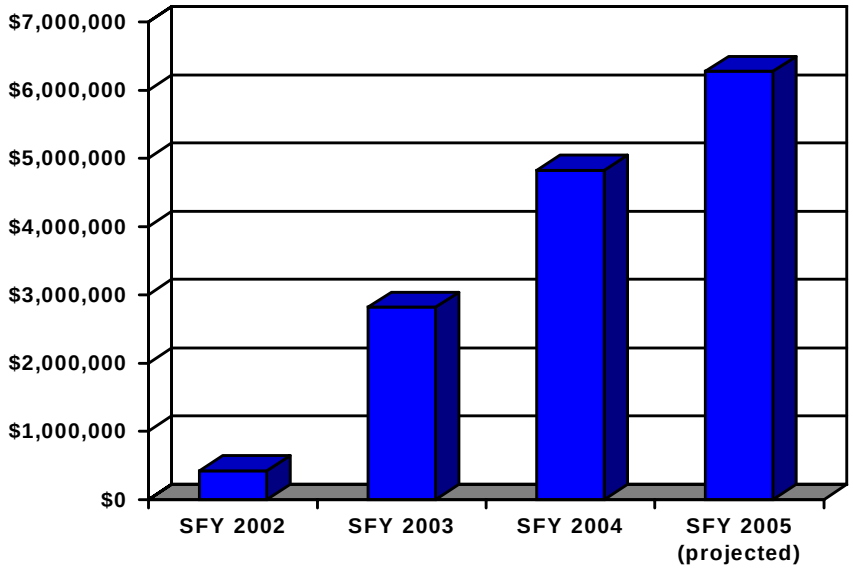
	SFY 2002	SFY 2003	SFY 2004	SFY 2005*
RIte Care Expenditures Avoided	$159.33	$154.39	$174.15	$186.10
RIte Share Expenditures	$79.35	$75.63	$94.29	$95.32
Gross RIte Share Savings	$79.98	$78.76	$79.86	$90.78
Net RIte Share Savings	($31.69)	$14.82	$19.01	$23.92

* July 1, 2004 to February 28, 2005

Figure 2, below, shows Gross RIte Care Savings, through February 28, 2005, graphically.

Figure 2

RIte Share Estimated and Projected Benefit Savings Through SFY 2005



5. Challenges Facing RIte Share

Several circumstances make it challenging for RIte Share to realize its full potential for enrollment:

- Employers are not required to submit information about their health insurance benefits to the Rhode Island Department of Human Services (DHS), making it difficult to transition RIte Care members to RIte Share.

- Federal ERISA laws pre-empt any State law that would require employers to enroll RIte Share-eligible families in the employer-sponsored health insurance outside of open enrollment periods.

- Federal Medicaid rules mandate different levels of benefits for family members (children, adults, and pregnant women) making it complex for RIte Share to offer different levels of wrap-around coverage within a family.

- Increases in premiums are being passed on to employees, making it more difficult to meet cost-effectiveness tests for Federal financial participation (FFP).

- Employers are adopting health plans with increased member cost-sharing (e.g., high deductibles) and scaled-down benefits that make it harder to "warp around".

- Health Savings Accounts (HSAs) and other flexible benefit programs make it more difficult to mandate that employees take up coverage.

The State will continue to transition Medicaid-eligible families who have access to ESI into RIte Share in an effort to contain the growth in the cost of health insurance for Medicaid enrollees, while simultaneously addressing the level of uninsurance in the State. The State's goal for RIte Share is clear: to enable Medicaid-eligible low income families to maintain or enroll in employer-sponsored coverage whenever it is available, rather than enroll in full publicly funded coverage (RIte Care). This allows the State to continue to provide coverage to low-income families using scarce public dollars most efficiently.

End Notes

1. Both Medicaid and State Children's Health Insurance Program (SCHIP) funds are used to finance the Federal portion of RIte Share, depending on the eligibility characteristics of individual family members.

2. The Federal Medical Assistance Percentage (FMAP) by eligibility category by SFY is as follows:

	SFY 2002	SFY 2003	SFY 2004	SFY 2005
Medicaid	52.79%	55.58%	58.82%	55.38%
SCHIP	66.95%	68.27%	69.11%	68.77%

3. This resulted in the following Federal and State savings percentage :

	SFY 2002	SFY 2003	SFY 2004	SFY 2005
Federal	61%	63%	65%	64%
State	39%	37%	35%	36%

4. The method of counting member months in the August 2004 report included inactive members with an active policy who had lost eligibility (e.g., parents who lost eligibility but whose children were still eligible and covered. The current methodology excludes inactive members within an active policy. This methodological change decreases the RIte Care Expenditures Avoided.

5. Supplementary Benefit Payments are stated on a "paid basis" to address "completion" concerns (i.e., incurred but not reported, or IBNR) on gap-style benefit payments. These payments are generally co-payments, deductibles, and for services that are non-covered or beyond benefit maximums stated in employer-sponsored insurance policies, and thus are not typically estimated in IBNRs.

6. Previous estimates for Supplementary Benefit Payments excluded direct member payments and professional claims for non-covered services under commercial plans that would otherwise be in-plan RIte Care benefits. Consequently, these estimates were decidedly understated as the cost-sharing program grew. Current estimates take this prior deficiency into account.

7. All estimates were calculated by HealthCare Analytics.

For more information, please contact: The Center for Child and Family Health, RI Department of Human Services, 401-462-2501.