Coverage at Risk:
State Actions to Keep Rhode Islanders Covered

Key findings and recommendations of the Marketplace Coverage Affordability Work Group

2025

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EXECUTIVE SUMMARY & RECOMMENDATIONS

HealthSource RI (HSRI) convened a Marketplace Coverage Affordability Work Group at the request of the Rhode Island General Assembly (2024-H 8332Aaa and 2024-S 3086Aaa) to address the expiration of enhanced federal Advanced Premium Tax Credits (APTCs) at the end of 2025. APTCs were expanded in 2021 as a part of the American Rescue Plan Act (ARPA), lowering the amount of household income Rhode Island residents must spend towards their health insurance costs when purchasing through the State Based Marketplace, HSRI, and newly offering APTC eligibility to households that were previously ineligible.

Barring state action, 88% of households enrolled with financial assistance through HSRI will experience an increase in their premium payment when enhanced APTCs expire at the end of 2025. Lower income households will experience the largest percentage impact when 2025 premiums increase an estimated 85% overall heading into 2026. Those with incomes around $60,000 (or $124,800 for a family of 4) will experience the largest dollar increase when they lose eligibility for APTCs entirely. This effect is particularly pronounced for older Rhode Islanders, who will see both the highest resulting premiums and premium increases if they lose access to APTCs.

As a result of premium increases, HSRI estimates that as many as 11,300 Rhode Islanders could lose coverage. Declines in individual market coverage pose costs both to uninsured individuals and to the healthcare system broadly. Uninsured individuals and families may be faced with insurmountable medical costs, or may suffer serious health impacts from avoiding or delaying care. Additionally, uninsurance also results in costs to the healthcare system, most notably through uncompensated care.

The Work Group was charged with examining affordability issues in the Rhode Island individual health insurance market and making recommendations for designing a state-based program to provide affordability assistance to Rhode Islanders enrolled in plans through HSRI. *Four Guiding Principles were agreed upon by the group:*

1. Protect the coverage gains achieved in Rhode Island under the Affordable Care Act (ACA), the American Rescue Plan Act (ARPA), and the Inflation Reduction Act (IRA);

2. Target state-funded assistance to maximize impact and address disparities in uninsurance and underinsurance;

3. Responsibly consider potential funding sources for the proposed program(s); and

4. Consider timing of assistance to best support predictability for carriers and customers.

The Work Group included various stakeholders, including members of the HSRI Advisory Board and representatives from the Office of the Health Insurance Commissioner, the Executive Office of Health and Human Services, health insurance carriers, healthcare providers, healthcare consumers, advocacy organizations, and representation from the RI business community.[1] The Work Group

1 Organizations that took part in the Marketplace Coverage Affordability Work Group included Blue Cross Blue Shield of Rhode Island, Economic Progress RI, Lifespan/Coastal Medical, Newport Chamber, Neighborhood Health Plan of Rhode Island, Northern RI Chamber of Commerce, Executive Office of Health and Human Services, Office of the Health Insurance Commissioner, Rhode Island Health Center Association, Rhode Island Parent Information Network, and VICTA.

met for six sessions between September 24, 2024, and January 16, 2025. The conveners provided background materials and invited national and local experts to provide an informed perspective on the topics being considered, including examples from other states. A syllabus for the six-meeting term was developed at the outset of the Work Group and adjusted as needed to respond to the pace and interests of the group. Meetings were open to the public with a virtual option, and minutes were taken and posted on the Secretary of State's website for each session.

At the conclusion of their six sessions together, the Marketplace Coverage Affordability Work Group reached a consensus that action should be taken, without delay, to protect Rhode Islanders from unaffordable premium increases. Absent action by the State or federal government, nearly all HSRI customers will see higher net premium costs when they shop for coverage this fall. For lower income individuals, such as those with incomes less than $30,000 annually, premiums will nearly triple. Some customers, for example those with annual incomes over $60,000 will lose eligibility for APTCs entirely. These customers will see household premiums increase by more than $6,000 annually, on average.

The cost of healthcare is only one of many expenses RI households must consider. In 2024 many Rhode Island households did not earn enough to make ends meet, and this was especially felt among Latino and Black households. In addition, many older Rhode Islanders are dependent on retirement income, which is not always sufficient to cover basic needs.[2] As premium growth continues to outpace wage growth and other costs of living increase, Rhode Islanders will face difficult decisions regarding their most basic and pressing needs.

Recommendations

The Marketplace Coverage Affordability Work Group submits four short-term recommendations, aligned with the Guiding Principles of the group:

1. **Establish a state-based premium subsidy program** to offset the severe post-APTC premium increases that HSRI customers will experience when enhanced APTCs expire. The Work Group recommends fully replacing enhanced APTCs through a state-based program to protect coverage gains and limit the growth in uninsurance and underinsurance that is expected to result from premium increases. Protecting coverage gains will:
    a. Protect individuals from the financial and health-related costs of uninsurance and underinsurance;
    b. Protect the stability of the individual market; and
    c. Protect the healthcare system from costs associated with rising rates of uninsurance and underinsurance.

2. In a scenario where state funding is constrained and a full replacement of enhanced APTCs is not financially feasible, the Work Group recommends that the state **design a state-based premium subsidy program that tailors assistance to maximize impact, targeting premium assistance in the following ways:**
    a. *As the first priority:* Fully replace enhanced APTCs for enrollees <200% FPL.
    b. *As the second priority:* Partially replace enhanced APTCs for enrollees >200% FPL, scaling the value of the replacement commensurate with available funding and the premium burden on enrollees.

2 The 2024 Rhode Island Standard of Need, The Economic Progress Institute

3. In addressing the Work Group's charge to responsibly consider sources of funds for a state-based affordability program, the Work Group reviewed and discussed a range of potential state funding sources. **While all sources of funding had merits and drawbacks, some options most closely aligned with the Work Group's guiding principles, and the Work Group offers two potential sources for further consideration:**
    a. State general revenue; and/or
    b. An insurer assessment that includes both fully insured and self-insured plans and leverages an existing mechanism to ease administrative burden and support timely implementation.

In the case that these two options are deemed infeasible, the Work Group emphasized that the importance of a state-based premium subsidy program necessitates identifying alternative sources of funds. Other funding source options discussed and identified by Work Group members are documented later in this report.

4. **The Work Group recommends that actions be taken, without delay, to implement the preceding recommendations.** The Work Group carefully considered the urgency of action and the timeline for implementation in recommending a state-based premium subsidy program. Timely implementation of this solution would necessitate action by the General Assembly within the current budget cycle to ensure that the program can be in place before Open Enrollment for 2026 coverage begins in November 2025. Carriers will begin to develop 2026 premium rates in February 2025, which will be filed with the RI Office of the Health Insurance Commissioner (OHIC) in May 2025, so timely guidance from OHIC to carriers about how to file rates in the context of any proposed state-based subsidy program would help address this challenging chronology.

In addition to the short-term recommendations above, the Work Group recommends that the state consider longer-term actions to address affordability in the individual market, particularly rising rates of underinsurance, which limits customers' ability to use insurance coverage at the point of service and can lead to foregone or delayed care and increasing medical debt. The Work Group specifically recommends that the state explore a state-based cost sharing subsidy program to enhance the value of coverage and improve the affordability and accessibility of care. The state should consider this option in the future when premium affordability is not a primary concern.

SUPPORT FOR PRINCIPLES AND RECOMMENDATIONS

By signing below, we each express our support for the Guiding Principles of the Work Group, and feel the report is an accurate reflection of the deliberations of this Work Group:

Print Full Name	Organization	Signature
ELENA NICOLELLA	RI HEALTH CENTER ASSOC.	Elena Nicolella
Elizabeth McClaine	Neighborhood Health Plan of RI	Elizabeth McClaine
Rich Silverman	Blue Cross + Blue Shield RI	RS
Stefanie Abate	Blue Cross Blue Shield RI	Stefanie Abate
Jamie Moran	Provider Group	Jamie Moran
Cory B. King	Office of the Health Insurance Commissioner	Cory B. King
Nina Harrison	Economic Progress Institute	Nina Harrison
Jacqueline Williams	Open Door Health	Jacqueline Williams
Lisa Peterson	VICTA	
Shamus Durac	RIPIN	
Linda Katz	Retired - Economic Progress Inst	Linda Katz
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SUMMARY OF WORK GROUP DISCUSSIONS AND FINDINGS

Background and Key Concerns

HealthSource RI (HSRI), Rhode Island's State-Based Marketplace, serves customers who do not have access to affordable employer-sponsored insurance (ESI) or government-sponsored insurance. HSRI has served as a one-stop shop for connecting individuals, families, and small businesses with high-quality, affordable health coverage for over ten years. HSRI is proud to serve as an unbiased resource for Rhode Islanders, helping them understand their coverage options and enroll in the plan that best suits their needs. Since 2013, HSRI has decreased Rhode Island's uninsured rate by more than two-thirds. As a result, in 2024, the state achieved an historic high of over 97% of Rhode Islanders with health coverage. In 2024, HSRI offered plans from two insurance carriers and insured approximately 46,000 individuals and families and over 8,000 small business enrollees throughout the state.

HSRI is the only source for eligible Rhode Islanders to receive federal financial assistance to lower the cost of health insurance. This financial assistance is only available to Rhode Islanders who cannot otherwise access affordable employer-sponsored insurance or government-sponsored insurance. This assistance is provided through tax credits known as Advanced Premium Tax Credits (APTCs), which reduce monthly premium costs and increase consumers' purchasing power. Approximately 23,000 households with an income less than 250% of the federal poverty level (FPL), and nearly 6,000 households with incomes between 250 and 400 percent of the FPL, were enrolled in coverage through HSRI with financial assistance in 2024. Moreover, nearly 90% of individuals and families enrolled in coverage through HSRI receive federal premium tax credits to help make health insurance coverage more affordable and attainable.

In 2021, as part of the American Rescue Plan Act (ARPA), APTCs were enhanced temporarily for two years (2021 and 2022). Specifically, ARPA lowered the sliding scale for the percent of income that enrollees should spend on exchange premiums, covering the difference with increased tax credits. The Inflation Reduction Act (IRA), passed in 2022, extended these enhanced tax credits for an additional three years. Enhanced APTCs are set to expire in December 2025 in the absence of Congressional action.

What is at risk?

Enhanced tax credits have made health insurance more affordable and attainable for many Rhode Islanders and have contributed to historically high enrollment levels through HSRI. Concurrently, Rhode Island's uninsured rate is at an historic low. The expiration of enhanced tax credits will have two primary impacts, which are described in turn.

1. Steep increases in premium payments for most HSRI enrollees and reduced affordability of medical services.
2. A reversal of recent gains in enrollment attributed to the introduction of the enhanced tax credits.

Risk #1: Affordability and Accessibility of Medical Services

Enhanced tax credits both reduce premium costs for enrollees at lower income levels and expand financial assistance to higher-income households that were not previously eligible for any assistance.

With enhanced tax credits:

- Lower-income households (<250% of the federal poverty level, or FPL) have seen substantial reductions in premium costs, with many qualifying for zero-dollar premiums.
- Middle-income households (250-400% FPL) have seen considerable reductions in premium costs.
- Higher-income households (400+% FPL) have become newly eligible for financial assistance, with premiums capped at 8.5% of household income.

In 2025, existing HSRI enrollees will be eligible for approximately **$40 million in additional financial assistance** through enhanced tax credits. 88% of currently enrolled households eligible for financial assistance through HSRI would see an increase in their premium payment without enhanced tax credits. 2025 premium costs would increase by an estimated 85% overall, with the largest percentage increases felt by lower income households and the largest dollar increases felt by those losing all assistance. The table below shows the share of households impacted and the average increase in 2025 premium cost for these households, absent enhanced tax credits.

HSRI Enrolled Households Eligible for Financial Assistance (as of July 2024)

Change in Average Monthly Household (HH) Premium without Enhanced Tax Credit

HH FPL		# Eligible for APTC	% with Increase in Premium	Average Monthly Premium (2025)				Total Annual APTC Loss	
				With eAPTC	Without eAPTC	$ Premium Increase	% Premium Increase	Eligible APTC	% of Total Eligible APTC
<200%	<150%	9,617	69%	$19	$54	$35	184%	$4,509,374	$15,309,316 (38%)
	150-200%	8,177	95%	$50	$150	$101	203%	$10,799,942	
200-250%	200-250%	5,132	96%	$110	$232	$122	111%	$8,293,387	$8,293,387 (21%)
250-400%	250-300%	3,246	97%	$198	$331	$133	67%	$5,540,378	$8,961,991 (22%)
	300-350%	1,836	99%	$317	$436	$120	38%	$2,691,920	
	350-400%	841	100%	$447	$519	$72	16%	$729,693	
>400%	>400%	1,237	100%	$749	$1,253	$505	67%	$7,490,263	$7,490,263 (19%)
Total Households		30,086	88%	$122	$226	$104	85%	$40,054,957	$40,054,957 (100%)
Total Enrollees		39,506	88%	$93	$172	$81	85%		

- This analysis measures the impact of enhanced tax credits for 2025, using 2025 applicable percentages and 2024 enrollment; no changes in plan selection for 2025 are assumed.
- Households at lower FPL levels: enrollees in this category who reported no household income have zero-dollar premiums, regardless of the enhanced tax credit.

Note that this analysis is based on 2024 enrollment and 2025 coverage parameters. Affordability parameters change annually, and the impact will therefore vary each year in the future. For the purposes of illustrating this effect, we conducted this analysis using affordability percentages from 2021, a year with higher parameters; this resulted in a total impact of $45 million, $5 million more than the loss estimated based on 2025 parameters.

HSRI enrollees will experience steep increases in their monthly premium payments in the absence of state action. The magnitude of these increases is dependent on multiple factors and will affect each enrollee uniquely. Furthermore, rising costs of living are constraining Rhode Islanders' budgets. In 2024 a single adult had $39,741/year in total expenses on average, and a single parent family with two children spent $83,239/year on average. Of these expenses, housing made up the largest share for single adults at 34% of annual expenses, and childcare dominated family budgets accounting for 25% of annual expenses. For all Rhode Islanders, healthcare expenses make up about 10% of all living costs.[3] *Below, we provide a few illustrative examples that demonstrate how the expiration of enhanced APTCs could impact current HSRI customers.*

Julian- 25 years old
$26,355 annual income (175% FPL), poor health, Woonsocket, RI

Julian recently moved from Oregon to Rhode Island and landed two part-time jobs, a greeter at his local Walmart, and a cashier at CVS. Julian is facing not only a change in residence, but also an increase in need for health care services due to a recent diabetes diagnosis. In the absence of enhanced APTCs, he will see his monthly premium increase from $22 to $107 (a 389%, $85 per month increase). This new, more costly premium will account for 5% of Julian's monthly income.

Dave and Maria- Both 35 years old
Combined income of $51,100 (250% FPL), good health, Warwick, RI

Dave and Maria are in their 30s and have a young child who qualifies for Medicaid coverage. As they're both self-employed – Dave is a self-employed carpenter, and Maria is a freelance graphic designer – they have sought health insurance coverage through HSRI. However, when enhanced APTCs expire, they will see their monthly premium increase from $170 to $326 (a 91%, $155 per month increase). This new premium represents 8% of their monthly income. With their family budget already stretched, Dave and Maria will have to make a difficult decision about whether to keep their coverage. Since they are in good health and their child is covered by Medicaid, Dave and Maria may decide to go without coverage for themselves, likely leading them to delay or defer care and putting them at risk for large medical costs in the event of an emergency.

3 The 2024 Rhode Island Standard of Need, The Economic Progress Institute

Carla, 60 years old
Retired with $60,240 annual income from her 401K (400% FPL), fair health, East Providence, RI

Carla recently retired from her job as a mental health counselor. As she does not qualify for Medicare yet, Carla sought insurance coverage through HSRI. With a family history of heart disease and her current hypertension, having health care coverage is important to Carla. When enhanced APTCs expire, Carla will see her monthly premium increase from $427 to $904 (a 112%, $477 per month increase). Carla's new monthly premium accounts for 18% of her monthly income. Because Carla values having health insurance, she decides to keep her coverage, but finds that paying for food, housing, insurance, and her needed medications becomes increasingly challenging, leading her to delay filling her prescriptions.

It is important to note that enhanced tax credits contribute to the affordability and accessibility of medical care more broadly. By reducing premium costs, enhanced tax credits also help some customers cut out-of-pocket expenses throughout the coverage year by enabling them to buy higher metal level plans with lower deductibles, more pre-deductible services, and less cost sharing.[4] Higher metal level plans make medical services more affordable and accessible – customers can more readily afford to stay covered and get the care they need. These plans also protect customers from large medical bills – while protecting doctors and hospital from the risk of unpaid bills.

Risk #2: Lost Enrollment Gains with a Subsequent Increase to the Rate of Uninsured

Enhanced tax credits have contributed to historically high levels of enrollment through HSRI, with concurrent reductions in the rate of uninsurance in Rhode Island.

Between February 2021 and July 2024, the number of individuals enrolled in coverage through HSRI increased by 42% – from 30,388 to 43,098. This growth was driven primarily by substantial growth in the number of households eligible for financial assistance – this segment grew by 55% – increasing the share of HSRI households eligible for financial assistance from 83% to 91%.

The substantial growth in the number of individuals eligible for financial assistance before and after enhanced tax credits was driven by increased enrollment amongst lower income individuals (47% growth) and middle-income individuals (44% growth). Notably, higher income individuals were eligible for premium tax credits for the first time, which resulted in approximately 2,300 higher income individuals newly eligible for financial assistance.

Enhanced tax credits have enabled improvements to how the state supports residents transitioning from Medicaid to HSRI. HSRI enrollment growth can be at least partially attributed to recent improvements the state made to better support transitions from Medicaid to Marketplace coverage for Rhode Islanders who lose Medicaid eligibility. From the start of Medicaid unwinding in April 2023 to April 2024, HSRI helped more than 14,000 individuals stay connected to coverage by transitioning from Medicaid to HSRI. Enhanced tax credits have enabled this transition by creating zero-dollar or low-cost premium plan options for low-income Rhode Islanders. HSRI leveraged this enhanced

4 Health insurance plans are sorted into metal levels according to their actuarial value (AV) or the percentage of total benefit costs the health insurer will pay - where higher AV values indicate more generous coverage and less consumer out-of-pockets costs.

affordability assistance to offer additional state-level premium assistance to effectuate coverage for certain Rhode Islanders coming through HSRI for health coverage. Absent enhanced tax credits, HSRI will be unable to continue auto-enrolling individuals transitioning off Medicaid coverage, likely reducing the rate of coverage retention for this population.

The impact of gains in coverage can be clearly seen in Rhode Island's uninsured rate. Concurrent with gains in HSRI enrollment, the state's uninsurance rate has steadily decreased – from 4.0% in 2020, to 2.9% in 2022, to 2.2% in 2024. This decrease has been primarily driven by a reduction in the number of uninsured individuals in lower income households, which decreased by 63% between 2020 and 2024. This decrease can be in part attributed to the increased financial assistance available to lower income households and the resulting gains in HSRI enrollment within this segment.

It is also worth noting that the expiration of enhanced tax credits poses a risk to marketplace stability and thus, affordability. A reduction in affordability assistance is likely to reverse gains in marketplace enrollment, with the likely outcome that the health status of remaining enrollees will be sicker, on average, than it is with enhanced tax credits. If insurers expect to lose their healthier enrollees, they may raise premiums heading into 2026. The Congressional Budget Office (CBO) released enrollment projections in July 2024 that consider the impact of the expiration of enhanced tax credits, in addition to other factors such as the end of pandemic-related Medicaid policies, and immigration. These estimates project a substantial decline in national marketplace enrollment when enhanced tax credits expire – from 23 million in 2025 to 19 million in 2026, a decrease of 4 million (17%). Enrollments with financial assistance are expected to decrease by 5 million (24%). CBO expects these declines to continue annually, resulting in a decrease in enrollment of 8 million (35%) between 2025 and 2030.[5]

Finally, declines in individual market coverage pose costs to both the healthcare system broadly and to uninsured individuals. Uninsurance and underinsurance result in costs to the healthcare system most notably through uncompensated care. This measure of healthcare system costs has decreased in tandem with the uninsured rate. Rhode Island hospital uncompensated care decreased 54% between 2011 and 2021 with the implementation of HSRI and the rest of the ACA both occurring within this time span. In addition, uninsured and underinsured individuals are less likely to access preventive care services, creating long-term costs to the health care system including increased hospitalizations and emergency department visits. Uninsured individuals themselves also face costs including foregone or delayed care, medical debt, and the RI individual mandate penalty.

If no state action is pursued, the expiration of enhanced tax credits will increase premiums substantially for enrollees. Rhode Islanders facing high and rising costs of living will likely find that premium increases further strain their budgets, forcing individuals to make difficult decisions regarding their health insurance – and resulting in reversals in coverage gains, increasing market instability, increasing costs for the healthcare system, and more uninsured Rhode Islanders who may delay or forego the care they need.

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5 Health Insurance Coverage Projections For The US Population And Sources Of Coverage, By Age, 2024–34
Jessica Hale, Nianyi Hong, Ben Hopkins, Sean Lyons, Eamon Molloy, and The Congressional Budget Office Coverage Team. Health Affairs 2024 43:7, 922-932

Affordability Program Options

The Work Group was charged with considering affordability program options that directly address both the monthly premium cost of health insurance obtained through HSRI and the out-of-pocket costs paid by enrollees that are currently addressed by enhanced tax credits under ARPA and cost-sharing reductions. In recommending the design of a state-based program, the group reviewed and thoughtfully discussed affordability programs already in place in Rhode Island and other states' efforts to address health insurance affordability.

Rhode Island currently has a few programs in place that aim to enhance accessibility and affordability of health insurance coverage. These include an 1115 waiver authorized state-based premium assistance program for parents and caregivers <175% FPL, the premium assistance and autoenrollment program for those transitioning from Medicaid to HSRI coverage, and the 1332 waiver reinsurance program that brings down premium costs through reimbursements to qualifying insurers. While the Work Group discussed the importance of Rhode Island's starting place for state-based affordability programs, the group generally agreed that a new program should be considered in the current context of the expiration of enhanced tax credits.

To this end, the Work Group discussed four types of state-based affordability programs: 1) premium subsidies, 2) cost-sharing subsidies, 3) the Basic Health Plan, and 4) standardized plan designs. Both premium subsidies and cost-sharing subsidies impact consumer affordability, whereas the Basic Health Plan impact care affordability, and standardized plan designs impact the design of coverage and the ability to compare plans.

Several states have enacted state-based premium subsidy programs, which range from flat dollar subsidies to scaled subsidies that are based on income. For example, Connecticut offers $0 premium silver-level Cost Sharing Reduction (CSR) plans to enrollees <175% FPL, and Washington provides subsidies to enrollees <250% FPL who are enrolled in the state's standardized plan or Public Option. New Jersey's premium subsidy increases with income and family size for enrollees up to 600% FPL. Other states, such as Massachusetts, New Mexico, and Vermont, have opted for sliding scale premium subsidies for those up to 500% FPL, 400% FPL, and 300% FPL, respectively. Some states have further tailored their subsidy programs to target specific populations, such as Colorado's undocumented persons subsidy, Maryland's young adult subsidy, and the District of Columbia's childcare facility employee subsidy.

The Work Group also considered options to enhance cost sharing subsidies, which largely impact underinsured enrollees. Most of the state examples in this category were programs that enhance the actuarial value of plans for certain income groups or for specific health concerns, such as enrollees with diabetes or pregnant enrollees. State examples reviewed included programs in California, Colorado, Connecticut, Massachusetts, New Mexico, New York, and Vermont.

Other affordability program options reviewed include a Basic Health Plan under Section 1331 of the ACA, which allows a state to design its own benefit, often Medicaid-like, using 95% of the APTC that otherwise would be provided to individual market enrollees <200% FPL. The last option the Work Group reviewed was standardized plan designs, which largely impact the design of coverage and how easily compared plans are by standardizing cost sharing, requiring that certain benefits are covered pre-deductible, or enacting deductible limits.

Assessment of Program Options

To assess the four state affordability program options, the Work Group considered each option against the four Guiding Principles: *protecting coverage gains, responsibly considering program cost, maximizing impact, and considering the timing of assistance.*

To support their deliberation, the Work Group reviewed an illustrative set of options for each affordability program that ranged from small to large impact and cost. The medium scenario for each affordability program was constructed to ease comparability across all affordability program types and to enable the Work Group to weigh program types against each other. This scenario included 1) replacing enhanced APTCs for customers <200% FPL in the context of state premium subsidies, 2) creating a $0 cost sharing plan for customers <200% FPL in the context of cost-sharing subsidies, and 3) creating a Basic Health Plan with $0 cost sharing and enhanced APTCs for customers <200% FPL. For the purposes of this report, the medium scenario for each program design is used to describe the group's assessment of the four program options, on each of the guiding principles.

- **Protecting Coverage Gains:** First, the group discussed what the impact of each program would be on enrollment retention. Current projections, based on CBO's assumptions, forecast a loss of around 11,300 HSRI individual market enrollments between 2024 and 2027. Because premium subsidies and basic health plans both affect the cost of health insurance premiums, fully replacing enhanced APTCs under these programs is expected to retain the entire population of customers <200% FPL. On the other hand, cost-sharing subsidies and standardized plan designs may improve the accessibility of covered services but do not directly affect premium costs. Because of this, enrollment retention estimates under these programs is smaller and more uncertain.
- **Responsibly Considering Program Cost:** Next, the state cost of each affordability option was discussed. Premium subsidies to replace enhanced APTCs for customers <200% FPL would cost approximately $15.3 million, cost-sharing subsidies to buy up actuarial value levels and create $0 cost sharing for customers <200% FPL would cost roughly $15.0 million, and a Basic Health Plan for customers <200% FPL that includes both premium subsidies and cost-sharing subsidies would cost approximately $36.7 million. Based on this comparison, the Basic Health Plan was determined to be a less cost-efficient option in RI's context for achieving the same outcome that could be achieved with a combination of premium and cost-sharing subsidies.[6]
- **Maximizing Impact:** To maximize the impact of an affordability program, the group considered the extent to which each program could be targeted to specific groups and the extent to which each could impact uninsurance and underinsurance. Premium subsidies can

6 This is primarily because the state would be able to use federal funding of 95%, but not 100% of APTCs this group would otherwise receive.

be broad or targeted depending on the program's design. These subsidies also have the potential to substantially mitigate increases in uninsurance due to coverage loss. Similarly, cost sharing subsidies are able to be designed to impact all enrollees or targeted to impact certain groups. While cost-sharing subsidies are not expected to have large impacts on uninsurance, they instead work to substantially reduce underinsurance. Basic health programs are more limited in their scope as they only apply to the population <200% FPL per ACA Section 1331. A Basic Health Plan could mitigate increases in uninsurance and reduce underinsurance, acknowledging that impact is highly dependent on plan design and financing. Standardized plan designs have flexibility to be broad based or targeted but are not expected to substantially impact uninsurance as they do not impact premium costs.

- **Considering the Timing of Assistance:** Finally, the time required to design and implement each program was considered from a customer, carrier, and HSRI perspective. Overall, premium subsidies emerged as the easiest for customers to understand, the easiest for carriers to implement, and the easiest for HSRI to administer since this program builds directly on the existing subsidy structure. Both cost-sharing subsidies and standardized plan designs require consumer education, plan design changes for carriers, and increased administrative complexity to implement. A basic health plan emerged as the most complex as this program would require a substantial administrative lift, federal negotiations and approval, and contracting with carriers.

After consideration of all affordability programs against the Work Group's Guiding Principles, consensus was reached that premium subsidies are best aligned with the Guiding Principles as they are directly responsive to the expiration of enhanced APTCs and are expected to have the greatest impact on protecting coverage gains and limiting the growth in uninsurance. The Work Group also agreed that while cost-sharing subsidies would improve the value of coverage and reduce underinsurance, they are expected to have a much more limited impact on protecting coverage gains and limiting growth in uninsurance. Therefore, the state may wish to consider this option in the future when premium affordability is not a primary concern. Similarly, standardized plan designs may be a longer-term option to improve the value of coverage, potentially with an emphasis on specific health conditions. The group agreed that a Basic Health Plan does not appear to be a good fit for Rhode Island as this program is less cost-efficient in the state's context and would require a large, multi-year administrative lift to design and operationalize.

State-Based Premium Subsidy Program Design Considerations

Having reached consensus that a state-based premium subsidy program would be the best fit option to address the expiration of enhanced APTCs, the group moved to consider how to responsibly design a premium subsidy program to maximize impact. The group's primary recommendation is a full replacement of enhanced APTCs. This would have the biggest impact on protecting coverage gains and limiting the growth in uninsurance and underinsurance that is expected to result when enhanced ATPCs expire. However, to the extent it would be challenging to fund a full replacement of enhanced APTCs and funding for this program is constrained, the group considered where to target available funds to maximize program impact.

To establish priorities for a tailored premium subsidy program, the Work Group considered three key questions:

1. Who is most impacted?
2. How much does it cost to target the highest impact populations?
3. If funding is constrained, how can scaling the subsidy restrain cost while still having an impact on program goals?

1. **Who is most impacted?**
   First, the group discussed which customers are most impacted by the expiration of enhanced APTCs. Two high impact groups were identified: HSRI customers <200% FPL, who will see the largest percent increases in premium, and who represent the largest number of households impacted, and HSRI customers >400% FPL, who represent a smaller number of households impacted but will see the largest dollar increases in premium. While FPL is the most significant factor driving impact, the group also discussed the distinct impacts by age that occur within the >400% FPL group. Because this group became newly eligible for financial assistance with the enhanced APTCs, expiration would predominately impact older enrollees whose age-adjusted premium costs are deemed unaffordable under enhanced APTC affordability standards. While premium increases do not vary by age for people <400% FPL because some level of tax credit remains in place, they vary substantially by age for people >400% FPL, with increases felt more severely by older enrollees.

   While Work Group members acknowledged the more severe impact within some age and FPL segments, they advocated for a solution that would provide a broad benefit, at least partially mitigating the premium increases that would be experienced across the FPL continuum.

2. **How much does it cost to target the highest impact populations?**
   The Work Group next considered the cost per retained enrollment of different program design options. Targeting customers <200% FPL costs the least per enrollment retained since the dollar value of the APTC reduction is lower for customers <200% FPL. By contrast, those over >400% FPL have the highest cost per enrollment retained as the dollar value of the enhanced APTC is by far the largest within this segment.

   Given the much lower cost per person impacted and the greater number of people impacted within the <200% FPL segment, the Work Group established the first priority for a state based premium subsidy program: Replace enhanced APTCs for enrollees <200% FPL.

3. **If funding is constrained, how can scaling the subsidy restrain cost while still having an impact on program goals?**
   Acknowledging Work Group members' preferences to at least partially mitigate premium increases broadly, the Work Group considered how scaling the value of the subsidy could restrain program cost. The Work Group reviewed scenarios demonstrating how scaling the affordability standard would impact both program cost and household premium increases. This lever could be used to enable a partial replacement of enhanced APTCs for enrollees >200% FPL, allowing the state to vary the value of the replacement based on the available funding and population impact, in a constrained funding scenario.

Work Group members generally agreed that the population >400% FPL were important to include in the design of the program, especially those 50 and above who would be the most impacted, from losing financial assistance with the return of the ACA "subsidy cliff." The members also noted that the population 200-250% FPL should be given consideration as they also face sizable increases and tight household budgets.

Assessment of Funding Mechanisms

The Joint Resolution that established the charge of the Work Group requested that the group study and report to the General Assembly as to potential funding mechanisms which could be designed and established to pay for a state-based affordability program and the positive and negative attributes of each funding mechanism, including, but not limited to, state general revenue, assessments on health insurance issuers, other assessments on health care industry entities, special assessments, proceeds from existing or new excise taxes, funds from the Rhode Island Health Insurance Mandate, and any federal funding source identified.

In addressing the Work Group's charge to responsibly consider sources of funds for a state-based affordability program, the Work Group reviewed and discussed a range of potential state funding sources and one potential source of federal funding.

With regards to federal funding sources, HSRI noted that Rhode Island currently has an 1115 waiver which provides federal Medicaid matching funds for a limited state-based premium subsidy program, and there may be an opportunity to leverage an 1115 wavier for an expansion of the current program. Other states, such as Connecticut, Massachusetts, and Vermont, have leveraged 1115 waivers for expanded premium subsidy programs. HSRI intends to work with Medicaid to explore any opportunities for federal match that could offset the state cost of a premium subsidy program. It is worth noting that an 1115 waiver would require close coordination with the Medicaid program and would be dependent on federal negotiations with CMS. Willingness to support a state-based premium subsidy program at the federal level will affect the likelihood that the state receives federal Medicaid matching funds.

The Work Group focused its attention on potential state funding sources, acknowledging that a state funding source would still be needed even with federal matching funds to partially fund the program. The potential state funding sources identified and discussed included:

1. **State General Revenue:** collected via statewide taxes and distributed annually to state programs through the state's budget process.
2. **Insurer Premium Tax:** RI's 2% insurer premium tax currently applies to gross premiums on contracts of insurance covering property and risks within the state. This tax applies to all types of insurance; it excludes self-insured and Medicare.
3. **ACA Health Insurance Tax:** The ACA Health Insurance Premium Tax was repealed by Congress, starting in 2021. The tax applied to fully insured plans, including the on-exchange and off-exchange individual market, large and small group markets, and any insured public programs including Medicare Advantage, Medicare Part D, and Medicaid Managed Care. The amount was 2.2% of premiums in 2020.[7] This tax excludes self-insured, and we assume a state-based program could not tax Medicare.

7 https://www.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf

4. **Insurer Healthcare Services Funding Contribution:** Currently, each insurer is required to pay the healthcare services funding contribution for each contribution enrollee of the insurer. The amount includes funding for various public health programs: child immunization funding, adult immunization funding, children's health services funding, and psychiatry resource network funding. This assessment excludes Medicare, and Medicaid is exempted from a portion of the Insurer Healthcare Services Funding Contribution (Children's Health Services).
5. **Insurer Surcharge on Healthcare Services:** RI does not currently have an insurer surcharge on healthcare services. Massachusetts leverages this mechanism to fund state-based premium subsidies for exchange enrollees, charging a 1.35% surcharge on total payments made to in-state acute hospitals and ambulatory surgical centers. Commercial plans (inclusive of Exchange carriers and self-insured plans/TPAs making payments on behalf of self-insured plans) are required to pay the surcharge; Medicare and Medicaid programs are excluded.[8]
6. **Provider Taxes:** RI has a number of provider taxes in place, including a tax on Nursing Facilities (5.5% of gross patient revenue) and a tax on Hospitals (tiered percentages for non-government owned hospitals, set as a % of inpatient and outpatient net patient service revenue; 5.25% of net patient service revenue for state government owned hospitals).
7. **Excise Taxes:** Rhode Island currently has excise taxes on numerous health and non-health related items. Among the health-related items, the state collected tax revenue on the sale and/or importation of cannabis, alcohol, cigarettes, tobacco products, and e-cigarettes – as of 2025.[9]
8. **Health Insurance Mandate:** Every individual required to file a personal income tax return is required to indicate for what amount of time during the year they were covered by minimum essential coverage. If the individual did not have minimum essential coverage, they are responsible for a shared responsibility payment penalty. Some individuals are exempted from this rule due to hardship, religious, and other determinations. Rhode Island's 2025 enacted budget includes $5.7 million from shared responsibility payments to fund the state's reinsurance program.[10]
9. **New Assessment:** Potential to define a new assessment and tailor it as needed.

The Work Group assessed each of the nine potential state funding sources by considering who the assessment is levied against, the financial feasibility of using the source to help pay for a state premium subsidy program, and the administrative feasibility of leveraging the funding source. Options 2 through 5 are levied on policyholders via their insurers, the provider tax applies to defined providers, excise taxes apply to consumers who use defined goods, and the health insurance mandate applies to uninsured Rhode Island residents.

When discussing the financial feasibility of each source, the group studied the increase in the assessment rate that would be needed to fund a full $40 million state-based affordability program as well as any current limitations to increasing the rate. The ACA health insurance tax, insurer healthcare services funding contribution, and insurer surcharge on healthcare services emerged as the most financially feasible mechanisms – in that they would require the smallest rate increases to fund a premium subsidy program and are not subject to other constraints such as rate caps that would limit their financial viability. Options 6, 7, and 8 were less feasible financially, as they currently raise less or about the same as would be needed for a full replacement of enhanced APTCs.

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8 https://www.mass.gov/info-details/surcharge-frequently-asked-questions#payment-process-for-institutional-surcharge-payers
9 https://tax.ri.gov/tax-sections/sales-excise-taxes
10 https://www.rilegislature.gov/housefiscalreport/2020/FY%202025%20Budget%20as%20Enacted%20-%20Budget%20at%20a%20Glance.pdf

Administrative feasibility was defined as whether the assessment would require new authority or complicated operational design. There was general agreement that to the extent a mechanism already existed in the state, it was more administratively achievable than establishing a new revenue generating mechanism. By this standard, the insurer surcharge on healthcare services and creation of a new assessment were considered low feasibility, the ACA health insurance tax and insurer healthcare services funding contribution were considered medium feasibility, and the remaining existing mechanisms were considered high feasibility.

Of the potential mechanisms for generating new state funds that the Work Group reviewed, broader based assessments were preferred. Of the funding sources discussed, two emerged as key interests of the group: (1) state general revenue and (2) an insurer tax that includes both fully insured and self-insured plans and leverages an existing mechanism to ease administrative burden and support timely implementation. Self-insured plan membership is predominantly from the largest employers and these plans are exempt from most forms of insurance taxes. A tax that is broad enough to include these plans would be more equitable and a lower rate than a tax solely on fully insured policies for employers and individuals. However, a tax on insurance will result in higher costs for policyholders, all else equal.

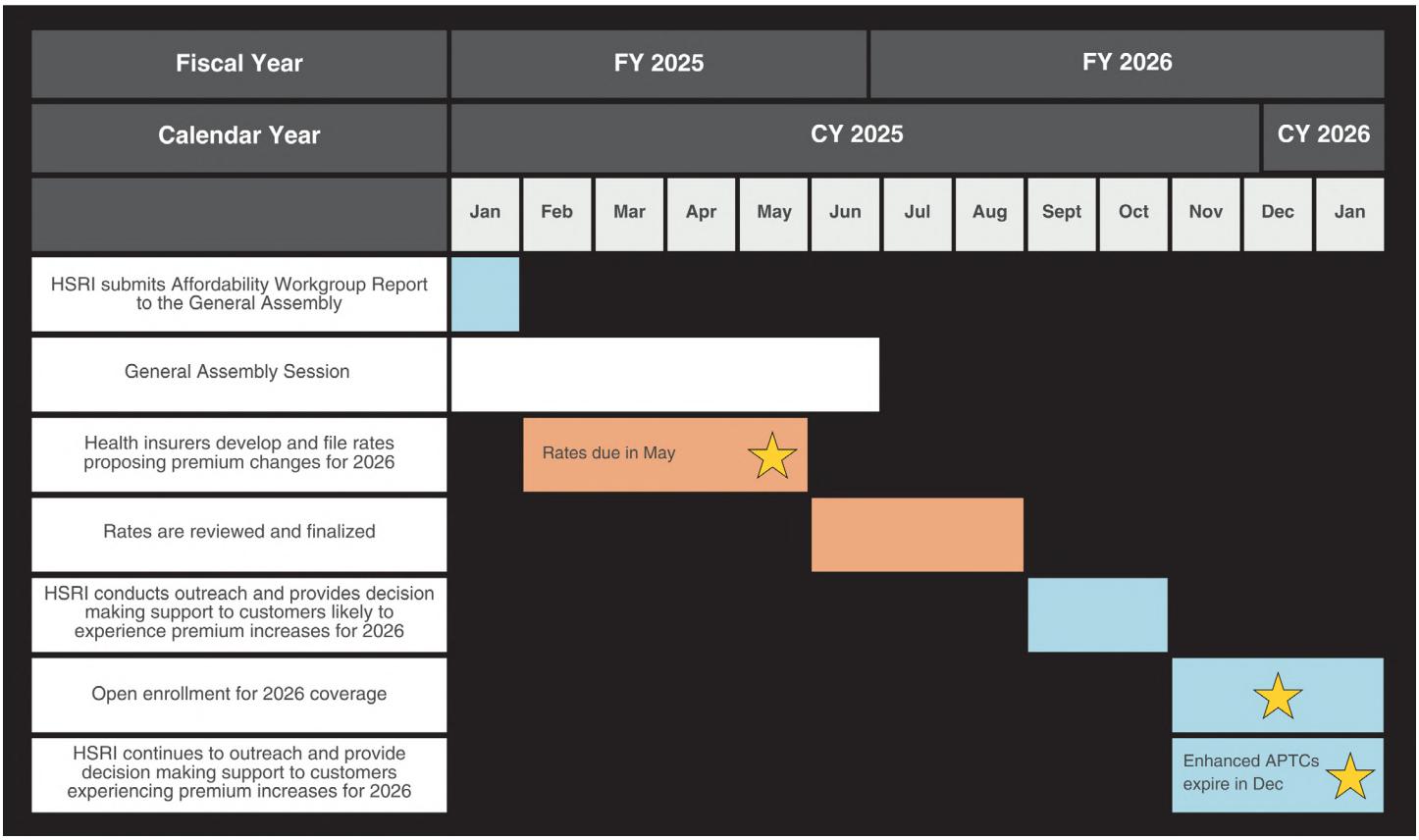
General revenue was supported by Work Group members as the most broad-based and efficient source of funding. In accordance with the request from the General Assembly to consider many funding sources, the Work Group discussed a new revenue generating mechanism to fund the program.

Work Group members were generally supportive of an insurer assessment that includes both fully insured and self-insured individuals, given concerns that an assessment on fully insured individuals only could lead to further migration to self-insured, and threaten the stability of the state's three fully insured markets. Work Group members also generally agreed that leveraging an existing mechanism would ease administrative burden and support timely implementation. Of the sources of funds the Work Group reviewed, the existing Healthcare Services Funding Contribution mechanism established by the Healthcare Services Funding Plan Act (RIGL § 42-7.4) best meets these criteria – in that it is an already established mechanism that includes both fully insured and self-insured plans.

In the case that these two recommended options are deemed infeasible, the Work Group emphasized the importance of identifying other sources of funds for a state-based premium subsidy program. Work Group members suggested a variety of alternative sources of funding including raising the excise tax on cannabis, a new assessment on vacant housing, new tolls or other taxes on tourism that would be partially paid by non-Rhode Island residents, and a tax on health insurer reserves.

Timeline for Action

In addition to funding mechanisms, the Work Group considered the timing of implementing a state premium assistance program in relation to Rhode Island carriers' rate-setting process. The expiration of enhanced tax credits will impact premium costs for 2026 coverage. Key milestones are as follows:



The Work Group carefully considered the urgency of action and the timeline for implementation in recommending a state-based premium subsidy program. In order to implement this solution, the General Assembly will have to take action within the current budget cycle to ensure that the program can be implemented before Open Enrollment for 2026 coverage begins in November 2025. Of note, carriers will begin to develop 2026 premium rates in February 2025, which will be filed with the RI Office of the Health Insurance Commissioner (OHIC) in May 2025. This could be supported by OHIC guidance to carriers about how to file rates in the context of any proposed state-based subsidy program.

APPENDIX: ESTIMATED ANNUAL COST FOR RECOMMENDATIONS ON STATE-BASED PREMIUM SUBSIDIES

Annual State Cost to Fund a Premium Subsidy Program)

Recommendation	Annual State Program Cost
1: Fully replace enhanced APTCs	$40.05 M
2: Fully replace enhanced APTCs for <200% FPL **and** partially replace enhanced APTCs for enrollees >200% FPL	$17.78 – $37.58 M (10% – 90% replacement of enhanced APTCs for enrollees >200% FPL)

Annual Program Cost by % Enhanced APTC Replacement for Enrollees >200% FPL

Note: Assumed Enrollees <200% FPL receive full enhanced APTC replacement ($15.31 M)

% Enhanced APTC Replaced	Total Program Cost (Millions)
10%	$17.78
20%	$20.26
30%	$22.73
40%	$25.21
50%	$27.68
60%	$30.16
70%	$32.63
80%	$35.11
90%	$37.58
100%	$40.05

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