New State Medicare for All Legislation

This new bill comes from the feedback we received on the old proposal from a wide array of stakeholders. In particular, we received the following concerns, which we have addressed:

- This is a very significant transition in the healthcare system, and it may be unrealistic to expect it to happen so fast.
    - Solution: A “warm transition” approach where significant changes are made to the healthcare system before the waiver process to prepare the state for the transition.
- Because the system is reliant on a waiver, no benefits could be delivered immediately upon passage of this legislation.
    - Solution: Begin improvements immediately, rather than waiting on the waiver for all changes.
- A significant percentage of the challenges of a Medicare for All system come from transitioning Medicaid to a Medicare standard of care. However, as only the Medicaid funding stream from the level of Medicaid at the time of the waiver transition process is available to the waiver, the state would likely be required to bear the burden of the costs of bringing the Medicaid population up to a Medicare standard of care *without federal Medicaid reimbursement*. This was a significant problem in Vermont.
    - Solution: Begin the transition to a Medicare level of care immediately, drawing down federal reimbursement funding streams that will remain in the waiver process.
- The RI provider network is currently facing critical system stress across multiple avenues, driven by a financial crisis from low Medicaid reimbursement rates and, particularly for hospitals, OHIC-imposed rate caps on insurance companies’ payments to providers. If RI were to transition to Medicare for All, the existing drivers of system collapse might cause significant problems that would be blamed on Medicare for All.
    - Solution: Immediately address the provider crisis. A significant component of this will happen through the immediate transition of Medicaid to a Medicare level of care. However, other steps will be needed. Rate caps authorization will be repealed. Payment methodology modernization will also be utilized, leveraging a transition to an innovative payment methodology, fee for service, which minimizes provider risk for a given cost level. Where a modernized payments model is not allowable pursuant to federal rules, mitigation steps shall be taken to optimize payment methodologies within allowable federal guidelines.
- The healthcare system in Rhode Island suffers from a workforce crisis due not only to wages and benefits but also due to a shortage of local medical education.
    - Solution: Expand the healthcare workforce through opening a new URI medical school as part of the warm transition period.
- RI’s health insurers have built up massive reserves from consumer payments in the private system. The old bill left those enormous quantities of capital in private hands, despite these reserves being built up to serve the interests of Rhode Island consumers, resulting in a significant net transfer of capital to corporate interests.

    - Solution: Transition that capital out of private insurers through a combination of taxation, modernizations to OHIC's regulatory goals, and general assembly prior authorization requirements placed on insurers for reductions in quality of coverage or price increases. Revenue from this process would fund the rapid transition of Medicaid to a Medicare standard of care.
- Medicare rates are insufficient to cover outpatient behavioral healthcare costs, so a transition to a purely Medicare-based rate setting could have an adverse impact on outpatient behavioral health in particular.
    - Solution: Reimburse outpatient behavioral healthcare at 150% of Medicare rates.
- The old bill's solution for out of state care was probably unworkable.
    - Solution: Offer to pay out of state providers at the average rate paid by commercial insurers. This is an expensive solution, but we don't want Rhode Islanders to lose access to care they need.
- More broadly, there was a desire for a more expensive benefits package.
    - Solution: Use the added funding from not losing federal reimbursements for bringing the Medicaid population up to a Medicare standard of care to fund more expansive benefits.
- The system is reliant on a federal waiver that realistically will probably only be granted under particular political conditions.
    - Solution: Create a backup plan not reliant on the waiver. The backup plan will use delegated state authority over insurance insolvency (the only area where states control insolvency processes) to transition Rhode Island's insurers into public management with a guarantee of public payment of claims. This will also make a waiver less politically difficult because it will be more of a simplification than a true transition.
- The political reality of the current federal Supreme Court may mean that any policy requiring complex federal approvals in complex areas could be undermined through politically motivated court rulings, such as a twisted and extreme view of ERISA preemption.
    - Solution: Create a backup plan not reliant on the waiver, focusing on insurance governance–an area where states have extensive jurisdiction. In particular, leverage states' expansive jurisdiction over the insurance insolvency process.
- The state does not have the experience, capacity, or personnel to run and manage the system.
    - Solution: Deprivatize Medicaid, deprivatize the Medicaid office, expand the Medicaid office, and acquire existing private insurers.

New legislation components

Transition Medicaid to a Medicare standard of care

This process takes up the vast majority of the new bill text. The entirety of the Medicaid statutes have been reviewed for necessary changes, the components of which are quite complex. The overall goal is to bring payments up to the Medicare equivalent level and, in order to manage costs, bring assessments up to the 6% standard across the board. This will represent a significant injection of funding into Rhode Island healthcare providers. To summarize the details, we quote certain components from the Medicaid resolution language starting on page 90 here:

(b) *Raising Hospital Licensing Fee.* The Executive Office proposes raising the hospital licensing fee to 6% and eliminating the reduced rate in Washington County.

(c) *Raising Nursing Facility Personal Needs Allowance.* The Executive Office proposes raising the personal needs allowance for nursing facility residents to $200.

(d) *Medicare Equivalent Rate.* The Executive Office proposes raising all Medicaid rates, except for hospital rates, nursing home rates, dental rates, and outpatient behavioral health rates to equal the Medicare equivalent rate. Specific to early intervention services, a $50 per member per month payment shall be established in addition to these rates, and a floor of a 50% rate increase shall be established within the calculation of the Medicare equivalent rate.

(e) *Setting Outpatient Behavioral Healthcare Rates at 150% of Medicare Equivalent Rates.* The Executive Office proposes to set outpatient behavioral health rates at 150% of the Medicare equivalent rate. The Executive Office will maximize federal financial participation if and when available, though state-only funds will be used if federal financial participation is not available.

(f) *Establishing a Nursing Facility Upper Payment Limit Payment.* The Executive Office proposes to establish an upper payment limit payment for nursing facilities.

(g) *FQHC APM Modernization.* The Executive Office proposes certain modifications to modernize and standardize the alternative payment methodology option for federally qualified health centers.

(h) *Hospital Payment Modernization.* The Executive Office proposes certain changes to hospital payment rates to modernize payment methodologies to encourage utilization and quality. Inpatient FFS DRG rates will be set at 90% of the Medicare equivalent rate, inpatient non-DRG FFS rates will be established at 95% of the Medicare equivalent rate, inpatient managed care rates will be set at 105% of FFS rates, and outpatient rates will be set at 100% of Medicare rates.

(i) *RIteShare Freedom of Choice.* The Executive Office proposes to make employee participation in the RIteShare program voluntary.

(j) *Elderly and Disabled Eligibility Expansion.* The Executive Office proposes expanding Medicaid eligibility for elderly and disabled residents to 133% of the federal poverty level.

(k) *Payments Streamlining*. The Executive Office proposes a multifaceted initiative to begin the phase-out of intermediary payers such as managed care entities, streamlining payments and reducing wasteful expenditures on intermediary payers.

(l) *Medicaid Office Expansion.* The Executive Office proposes an expansion of Medicaid office staffing to improve administrative capacities.

(m) *COVID-19 Adjustments to Health System Transformation Project.* The Executive Office proposes to eliminate the imposition of downside risk as part of the Health System Transformation Project to protect the solvency of providers in light of the COVID-19 pandemic.

(n) *Rhode Island Institute for Mental Disease.* The Executive Office proposes to construct a new Institution for Mental Disease (IMD) to serve vulnerable Rhode Island residents. The Executive Office seeks a waiver of the IMD exclusion rule similar to that granted to Vermont to allow federal Medicaid reimbursement.

(o) *Extend Post-Partum Medicaid Coverage.* The Executive Office proposes extending the continuous coverage of full benefit medical assistance from sixty (60) days to twelve (12) months postpartum to women who are (1) not eligible for Medicaid under another Medicaid eligibility category, or (2) do not have qualified immigrant status for Medicaid whose births are financed by Medicaid through coverage of the child and currently only receive state-only extended family planning benefits postpartum.

(p) *Extending Medical Coverage to Residents Previously Ineligible*. The Executive Office proposes to expand access to Medicaid to all residents without regard to immigration status. The Executive Office will maximize federal financial participation if and when available, though state-only funds will be used if federal financial participation is not available.

(q) *Raising Nursing Facility Assessment Rate.* The Executive Office proposes to raise the nursing facility assessment rate to 6%.

(r) *Universal Provider Assessment.* Consistent with overall goals of transitioning all services to a model where rates are at the Medicare equivalent rate, the Executive Office proposes to extend the existing nursing facility assessment model to cover all providers eligible for taxation under federal regulations to help defray the costs of the state component.

(s) *Dental Optimization.* The Executive Office proposes to make an array of changes to dental benefits offered under Medicaid. Rates will be pegged to the rates utilized in Massachusetts; billing will be extended to teledentistry services, Silver Diamine Fluoride (code D1354), and denture billing (codes D5130, D5140, D5221, D5222, D5213, and D5214); the mobile dentistry encounter rate will be raised to the FQHC rate; and a 50% payment shall be established for undeliverable dentures.

(t) *Commencement of Inpatient Substance Use Disorder Recovery Bed Federal Billing.* The Executive Office proposes to utilize the IMD waiver authority granted in 2019 to begin federal reimbursement billing for inpatient substance use disorder recovery beds, a service that will also see a rate increase pursuant to (d). The Executive Office also proposes a general obligation bond referendum to fund the necessary capital expenditures associated with the expansion of RICLAS to inpatient substance use disorder recovery services.

(u) *Coverage of Abortion Services.* The Executive Office proposes to end the exclusion of abortion care from covered Medicaid services. The Executive Office will maximize federal financial participation if and when available, though state-only funds will be used if federal financial participation is not available.

Not fully included in the copied resolution language is the plan for Eleanor Slater and behavioral health. To begin with, a Rhode Island Institute for Mental Disease will be created to help with the IMD exclusion problem. Additionally, Eleanor Slater Hospital and the newly created Rhode Island Institution for Mental Disease will receive $50 million in bond funds for capital improvements. To address the continuum of care crisis, a direct $300 million capital investment is made in RICLAS. This is subdivided into three categories: The existing RICLAS group homes program receives a $100 million capital infusion to invest in existing facilities and build or acquire new ones. RICLAS receives $100 million to build an assisted living-level care facility or facilities for behavioral health needs. Finally, RICLAS receives $100 million to build inpatient substance use disorder recovery facilities, which will be operated using new federal reimbursement authority.

Significant changes have been made, but likely more work is needed to complete this. Specific elements that are still needed include:

1. Figuring out the right payments system for nursing homes. This legislation creates a UPL payment for nursing homes as an immediate intervention to bring their payments up to the Medicare level. However, the extant payments system is left intact, except for some minor modifications. An area of improvement is to sort out the exact right payments structure for nursing homes.
2. Figuring out the exact right changes to make to behavioral health rates and how to put those changes into statutory language. This involves understanding some complex and specific federal rules around this area.
3. Determine if additional legislation is needed to support the RICLAS expansion.
4. Improve post-eligibility verification processes and eligibility processes in general.
5. Research areas for going above Medicare and continuing federal reimbursement under federal rules.
6. Research areas where the Medicare equivalent language would be hard to implement, in addition to dental.

Funding for the Medicare standard of care for Medicaid comes from three places:

1. Raising the insurance premium tax to 3% across the board for all insurers.
2. Maximizing the allowable direct 6% assessment across all allowable provider types.
3. Increases in various taxes from the effects of these policies. Higher reimbursement will increase provider taxes, and it will fund increased healthcare employment, which will bring higher income taxes. Indirect effects are probably considerable but are not included in the direct revenue model.
4. Raising insurance premium taxes on health insurance companies specifically to cover the remaining gap.

Areas for additional research include understanding federal limits on insurance taxation and pricing out the specific costs to see how it all balances out. A fiscal note would help immensely with sorting this out.

Transition existing private insurers

The plan here is for existing private insurers to no longer be governed by the state to ensure solvency and allow for profits. Instead, rate increases, benefit cuts, etc. will only be allowed with prior authorization of the general assembly, even if approved under OHIC's rate setting authority. OHIC will also gain the ability to deny compensation packages in excess of $1 million per year to any health insurance executive. OHIC's rate setting is guided to ensure a draw-down of reserves. At the same time, these insurers will face significantly increased taxation and other requirements. OHIC's authority to set rate caps will be repealed. Collectively, these policies should allow for recovery of the reserves balances consumers have placed in insurers' hands. Once those reserves are drawn down, health insurers may enter insolvency. At this point, the value of the insurance companies will be very low due to the conditions creating insolvency, and the state will then be able to acquire the insurers, managing them out of the Medicaid office and guaranteeing all claims. Insurers will face very stiff penalties for any interruption of claims during insolvency. The state will gain the right of first refusal for acquisition of health insurers, and the guarantee association will be required to pay the costs. (To prevent against inappropriate activity at the guarantee association and ensure compliance with Article IX, Section 5 of the Rhode Island Constitution, a state-appointed board will be created at the guarantee association.) Once all insurers are acquired, the state will have effectively transitioned to a form of single payer and can run the health insurance market for the state. Rate setting authority and prior authorization can be used to prevent a private insurer from forming to undercut the consolidated state-run insurer.

The key advantage of this system is to allow a form of single payer to be built in Rhode Island without the need for federal approvals that may be difficult to obtain. Once all health insurers are state-run, the waiver transition will be more of a streamlining and should be easier to actualize.

Additional improvements to this component of the legislation should focus on stricter regulation of insurance companies and overhaul of insurance governance legislation to mitigate industry bad practices. The basic idea is that insurance companies should be compelled to perform at the standard of single payer, and if that causes insolvency, then they should be smoothly transitioned to public management.

Remaining areas for legislation improvement:

1. Lowering costs. There are many good, progressive interventions in the healthcare system that we could devise to lower costs. Most of these involve addressing social determinants of health in a real way. Some of them involve decriminalization. Those components of the bill I had intended to begin adding, but they are very complex to write. There's probably 300 pages of this that should eventually go into a final bill.
2. Plans for expanding local medical education at the non-doctor level. The URI med school should only be a part of an overall expansion in local medical education. It should also include nursing, mental health professionals, social workers, etc.