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Finance and Sustainability Advisory Committee

AGENDA ITEM

[X] **For Possible Action**
[ ] **Information Only**

Date: March 19, 2012

Item Number: V

Title: Financing options for the Exchange

Summary

This report provides information regarding the key principles and various financing options for the Exchange and includes various methods that other states are using or may use.

Report

Key Principles

In developing the financing options of the Exchange, the Committee should consider the following key principles (taken from Finance and Sustainability Advisory Committee: Report to the Maryland Health Benefit Exchange Board November 15, 2011):

1. **Stability, Reliability, and Predictability** – The ability of the Exchange to balance expenses and revenue during uncertain economic times is critical. The financing mechanism(s) for the Exchange should be stable, reliable, and predictable at different levels of enrollment, and in keeping with the federal mandate for state exchanges. This may mean considering a combination of financing mechanisms.

2. **Encouraging Participation** – The Exchange should be financed in a way that maximizes participation by consumers, carriers, health care providers, and other individuals and

entities. Similarly, financing mechanisms should avoid discouraging participation, such as having high fees for consumers or carriers. Encouraging participation will also depend on the investment in and effectiveness of outreach and education.

3. **Minimizing Adverse Market Impacts** – The Exchange should be financed in a way that minimizes adverse market impacts. For example, some financing mechanisms could create a competitive disadvantage for carriers inside or outside the Exchange. The methods of financing could also affect whether health care providers or other entities choose to conduct business with the Exchange, due either to high costs or low reimbursement rates.

4. **Flexibility** – The financing mechanisms should be flexible enough to ensure necessary resources over time. The initial cost of the Exchange is likely going to be high (at least on a per member basis) as it develops technologically and adjusts to new market conditions. In addition, enrollment is expected to increase over the life of the Exchange, with initial enrollees primarily being those who are eligible for premium tax credits and cost sharing subsidies. Any financing mechanism needs to be flexible enough to have the ability to adjust as the Exchange gets off the ground and as its enrollment mix changes over time. Flexibility could be achieved in part by utilizing multiple revenue sources to finance the Exchange.

5. **Sustainability Options** – The financing mechanisms should reflect the state's objectives for the Exchange. If the state wishes to frame the Exchange as a business, then the financing could be dependent on those who conduct business with the Exchange – namely, individuals and businesses purchasing insurance and carriers selling insurance through the Exchange. If the state wishes to convey the value the Exchange adds to the entire market, the financing mechanisms could be broader to include carriers inside and outside the Exchange, health care providers, or other entities who benefit from the decrease in uncompensated care and an overall healthier population. If the state wishes to frame the Exchange as a public good, the financing mechanism(s) could include an even broader range of health care stakeholders and/or the general public.

6. **Routine Monitoring, Evaluation and Accountability** – The Exchange budget, financing, and mechanisms for preventing fraud, waste, and abuse should be subject to routine evaluation and annual adjustment. Such evaluations should consider their sufficiency and stability as well as the impact they have on the public, public health, and the health care market generally, including enrollees, carriers, providers, etc. These evaluations should include an assessment of the impact the Exchange is having on health care costs. Reports of these assessments should be widely available and used to inform the continuous improvement of the Exchange.

7. **Transparency** – The budget and financing mechanisms should be transparent to consumers. Transparency is a key principle of the ACA and should be upheld in the financing of the Exchange.

8. **Protecting Special Populations** – The budget and financing mechanisms should ensure access to affordable health care for vulnerable and underserved populations and protect them from excessive user fees and other harmful barriers to coverage.

Possible Funding Methods

At the March 9, 2012 Finance and Sustainability Advisory Committee Meeting, the Committee discussed the following funding options and issues:

a. User/licensing fees to Qualified Health Plan issuers or consumers
b. Monthly/annual fees based on Exchange enrollment or percent of premium
c. Assessment on all issuers in Nevada
d. State General Fund
e. User/licensing/referral fees to dental/vision/Medicare products
f. Advertising fees
g. The differences in fees while most Exchange operations are funded via Federal grant (prior to January 1, 2015) and fees when the Exchange is required to be self-sufficient
h. Funding the Navigator Program prior to initial coverage (January 1, 2014) and during calendar year 2014 (Navigator programs may not be paid with Federal funds)

Out of that discussion the Committee asked the following questions:

1. When is the Navigator Program required to be operational?

   According to the final regulations that were issued on Monday, March 12th by the Center for Consumer Information and Insurance Oversight (CCIIO), there is no requirement that the Navigator program be operational by a specific date. In the comments/response section of the final rules,[1] the following section addresses this issue:

   > Comment: We received many comments expressing support for a standard that Navigator programs be operational with services available to consumers no later than the first day of the initial open enrollment period. Some commenters noted that while they support the proposed start date, they prefer an earlier operational start date.
   >
   > Response: We have not directed Navigator programs to be operational by the first day of the initial open enrollment period. However, we encourage Navigator programs to be operational with services available to consumers by October 1, 2013, for State-based Exchanges that are approved or conditionally approved by January 1, 2013, or the start of any annual open enrollment period in subsequent years for State-based Exchanges certified after January 1, 2013.

[1] DEPARTMENT OF HEALTH AND HUMAN SERVICES, 45 CFR Parts 155, 156, and 157, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," Page 84.

2. What are other states doing for their funding?

- Utah assesses a $43.00 per subscriber[2] per month fee to support its operations. The fee, which is added to the monthly premium, is used to fund brokers and the administrative infrastructure of the Exchange (with $37.00 provided as payment to brokers and $6.00 retained by the Exchange to pay the administrative costs associated with facilitating enrollment and aggregating premiums on behalf of the insurers). Brokers, under the Utah Exchange model, assume primary responsibility for providing enrollment assistance to employers and employees. In addition, Utah's Exchange, which is administered by the Governor's Office of Economic Development, receives $600,000 from the state to support its operations.

  It is important to point out a few key differences—all of which have cost implications—between Utah's Exchange and the Exchange requirements of the Patient Protection and Affordable Care Act (ACA). Utah's Exchange (1) does not sell insurance to individuals, (2) does not offer premium subsidies, and (3) does not determine eligibility for subsidized coverage.

- Massachusetts retains three (3) percent of monthly premiums (roughly $12.00 per subscriber) to fund its administrative costs. Unlike the Utah Exchange, the Massachusetts Connector offers subsidized and unsubsidized health insurance to individuals, as well as unsubsidized health insurance to small employers. Although there are some meaningful differences between the Massachusetts Connector and the ACA Exchange, the federal requirements of an Exchange are modeled largely after the Massachusetts Connector.

- Alabama Health Insurance Exchange Study Commission voted 9–6 to recommend the Exchange be funded through an assessment on all products sold in the small group and individual markets, including those sold inside and outside the Exchange. The Commissioners voting "no" supported an assessment on only those small group and individual products sold through the Alabama Exchange. This recommendation was used by Alabama's governor to prepare legislation introduced in the Alabama legislative session that began on February 7, 2012. However, the decision has not yet been finalized.

- To staff's knowledge no other state has finalized its funding methodology.

[2] A subscriber is the holder of the contract, as opposed to a member, who may be the holder of the policy or a spouse or dependent of the policyholder. Several members may be under a single subscriber.

The following provides general information regarding the possible funding options for the Exchange:

a. Per member per month fees or other fees to Qualified Health Plan (QHP) issuers or consumers
    - Fees that are charged as a percent of premium are higher for plans with higher premiums and lower for plans with lower premiums, which may incentivize carriers to provide lower cost, leaner benefit plans. Flat dollar amount monthly fees are larger as a percent for lower cost leaner plans and therefore may incentivize carriers to provide richer plans.
    - Fees that are charged to QHP issuers can make it difficult for the carrier to meet the Medical Loss Ratio (MLR) requirements of the ACA. Fees that are charged to the consumer may not be subsidized through the premium tax credit program.
b. Assessment on all issuers in Nevada
    - An assessment on only plans within the Exchange is likely to be more volatile as enrollment changes within the Exchange. It will also be higher as there are fewer enrollees to charge the fee. However, the Exchange functions very much like a business and as such, some argue, it should receive revenue only from its clients within the Exchange.
    - An assessment on all individual and small group health plans, both inside and outside the Exchange, will be more stable and lower per member cost. However, because it affects plans outside the Exchange, it will likely require legislation.
c. User/licensing/referral fees to dental/vision/Medicare products
    - These items have been included in the proposed budget on the following pages. The budget assumes 10% participation in the dental plan at $0.30 PMPM, 5% participation in the vision plan at $0.10 PMPM and 1% of all Medicare enrollees referred to a Medicare exchange at $10.00 per referral.
d. Advertising fees
    - The proposed budget includes $25,000 in annual advertising revenue. However, staff needs to confirm whether state facilities can be used for advertising.
e. The differences in fees while most Exchange operations are funded via Federal grant (prior to January 1, 2015) and fees when the Exchange is required to be self-sufficient
    - Staff has proposed a slow increase in PMPM fees of $0.50 per year for three years. An unchanging fee is unrealistic because it would generate excessive reserves. A reserve between 30 and 45 days provides enough operational cash to absorb spending fluctuations. The fee schedule provided creates a slightly excessive reserve in Fiscal Years 2015 and 2016, but returns to normal levels by Fiscal Year 2017.
f. Funding the Navigator Program prior to initial coverage (January 1, 2014) and during calendar year 2014 (Navigator programs may not be paid with Federal funds)
    - Staff recommends utilizing a General Fund advance as allowed by NRS 695I.510.
g. Other possible fees or funding methods

Five Year Revenue and Reserve Budget

The five year budget of revenues and reserves provided below was designed to provide an illustration of the change in PMPM fees. A breakdown of expenditures can be found in Agenda Item IV. Exchange enrollment was based on a report compiled by Thompson Reuters for Nevada.

Projected Budget	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Average Annual Enrollment	0	51,000	124,000	199,500	266,000
PMPM Fee (No Reserves)	$0.00	$0.52	$4.70	$8.02	$7.64
PMPM Fee Charged	$0.00	$6.00	$6.50	$7.00	$7.50
Revenue					
Federal Grants	21,251,706	25,941,158	6,730,125	0	0
Medicaid/CHIP Cost Allocation	300,471	197,560	272,160	430,710	570,360
Fees on Dental Plans	0	18,360	44,640	71,820	95,760
Fees on Vision Plans	0	3,060	7,440	11,970	15,960
Medicare Referral Fees	0	16,175	33,850	35,300	36,550
Advertising Revenue	0	25,000	25,000	25,000	25,000
Fees on QHPs	0	3,672,000	9,672,000	16,758,000	23,940,000
Total Revenue	21,552,177	29,873,313	16,785,215	17,332,800	24,683,630
Expenditures	21,552,177	26,518,718	14,112,411	19,786,611	25,133,211
Cash Reserves	0	3,354,595	6,027,400	3,573,589	3,124,008
Days of Reserve		46	154	65	45

Staff will update revenues as better estimates become available.

Recommendation:

1. Recommend the Board accept the key principles for financing the Exchange as provided in the first section of this report.
2. Recommend the Board fund the Exchange through a PMPM assessment of either:
    a. Enrollment of QHPs offered on the Exchange; or
    b. Enrollment of plans offered in the entire individual and small group market.
3. Recommend the Board approve a gradual increase in the QHP enrollment fee as illustrated on this page.

4. Recommend the Board charge user/licensing/referral fees to dental/vision/Medicare products.
5. Recommend the Board charge advertising fees, pending staff's confirmation that state facilities can be used for advertising.