Vermont Legislative Joint Fiscal Office

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ISSUE BRIEF

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Potential Impacts of Opting for a Federally Facilitated Exchange in Vermont

In January, the Shumlin Administration released its exchange financing report, which estimated that the Vermont-run exchange as envisioned would cost between $16.9 million and $20.9 million to operate in 2015, when the exchange must be self-sustaining. Vermont has already informed the federal government of its intent to operate its own exchange, been awarded over $125 million in federal establishment grants, begun implementing the exchange, and expects to be operational in October. However, questions have recently arisen as to the appropriate cost to run Vermont's exchange and how much a state-run exchange in Vermont compares cost-wise to what a federally facilitated exchange would cost.

Such a comparison is both complicated and uncertain at best because a federally facilitated exchange carries with it a series of policy differences which the Legislature and the Administration would have to address. Given the short timeframe of when the exchange must be operational and the realistic challenges of opting for a federal-exchange at this point in the process, the following analysis is more of a hypothetical exercise.

To fund and support the operation of a federally facilitated exchange, the federal government has stated that participating insurers will pay a monthly user fee. For the 2014 benefit year, it set a monthly user fee of 3.5% of the premiums charged by the insurer for its products in the exchange. These user fees would support activities such as the consumer outreach, information and assistance activities.[1]

If Vermont opted for a federally-run exchange, a 3.5% user fee in 2014 would raise an estimated $13.4 million, which works out to a per-member per-month rate of approximately $13.42. ***It is important to note that the amount of money such a user-fee would raise in Vermont does not necessarily reflect how much it would actually cost the federal government to develop and run the exchange.***

Estimated Enrollments & Earned Premiums based on 3/25/13 Initial Rate Filings.

	Avg. Enrollment	Member Months	Earned Premium	3.5%	Est. PMPM
BCBSVT	63,222	758,664	$291,800,000	$10,213,000	$13.46
MVP	20,175	242,105	$91,790,821	$3,212,679	$13.27
TOTAL	*83,397*	*1,000,769*	*383,590,821*	*13,425,679*	*$13.42*

In addition to cost, there are many other factors to consider when comparing a state-run versus a federally-run exchange, such as regulatory differences, covered benefits, availability of premium tax credits and cost-sharing subsidies, compatibility with Medicaid, and consumer experience.

[1] Center for Medicare & Medicaid Services FAQ (Dec. 10, 2012). http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

For instance, there is dispute over the availability of premium tax credits and cost-sharing subsidies for lower-income individuals purchasing coverage through a federally facilitated exchange. The language of the Affordable Care Act leaves some room for interpretation, though the Internal Revenue Service (IRS) has issued regulations stating that tax credits will be available through ALL exchanges, regardless of how an exchange will be administered.[2] The State of Oklahoma has already filed suit in federal court to challenge, among other claims, these IRS regulations. If a court determined that beneficiaries in federally-run exchanges are not eligible for premium tax credits and cost-sharing subsidies and Vermont had opted for a federally-run exchange, it would mean a loss of over $100 million per year in subsidies to Vermont beneficiaries. And regardless of the availability of federal premium tax credits and cost-sharing subsidies, allowing the federal government to run the exchange in Vermont could significantly impair the state's ability to provide additional premium tax credits and cost-sharing subsidies because the state would have no role in exchange operation.[3]

Other factors to consider when comparing state-run versus federally-run exchanges include regulatory differences (the dynamic between a federal-exchange and Vermont's current regulatory controls and consumer protections); covered benefits (whether the federal government would alter the essential benefit package already chosen by the state which maintains Vermont's current insurance mandates); and compatibility with Medicaid (would the two IT eligibility systems be able to "talk" to or interface with each other).

There may be additional fiscal and policy implications if Vermont opts for a federally facilitated exchange. To date Vermont has been awarded over $125 million in federal grants for the establishment of a state-run exchange, likely the most of any state relative to population size, with the potential of being awarded up to an additional 25% in federal funding. While it is probably unlikely the federal government would ask for any of the money back, it could decide to withhold dollars the state has not yet received.

Choosing a federally-run exchange could also have significant fiscal implications for the state's plan to move to a universal and unified health care system in 2017. The state is currently using exchange-related grants from the federal government to develop exchange eligibility and enrollment systems with this transition in mind, whereas a federal system would not build in similar flexibility.

Finally choosing to move from a state-run exchange to a federally-run exchange less than six months before the exchange is due to begin enrollment would likely be looked on unfavorably by the federal government and could sour Vermont's relationship with the Center for Medicare and Medicaid Services (CMS), with repercussions potentially effecting not only the exchange but also the state's negotiations for renewing the *Global Commitment to Health* 1115 Medicaid Waiver.

As the October 1 "go-live" date looms, transitioning planning from a state-run exchange to a federal exchange is not something that can easily be done at this point or even in the short-term. Staff have been hired, contracts have been signed, and systems are already being built. There are many questions and considerations that would need to be addressed promptly if the state were to change its plan to operate a state-run exchange.

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[2] Health Affairs. Health Policy Brief. January 31, 2013.
http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=84

[3] Additional state premium tax credits and cost-sharing subsidies are included in H. 530 as passed in the house.