Small States' Big Struggle to Fund Health Exchanges

Facing high costs but smaller budgets, states like Hawaii and Rhode Island are struggling to find financially and politically sustainable ways to keep their health exchanges running.

by Chris Kardish | February 17, 2015

http://www.governing.com/topics/health-human-services/gov-funding-health-exchanges-in-small-states.html

Sent to Committee by Rep. Tim Briglin on

Jeff Kissel's first task when he took over Hawaii's health exchange was making sure it worked after a botched first year, but a close second was finding a way to pay for it. The former gas utility CEO is now lobbying his legislature -- what he calls "taking a forceful stand for why this business decision works"-- to keep the exchange's lights on.

It's a familiar role for many of the people leading the 14 state-run health exchanges. All of them are still struggling to find a funding formula that's financially and politically viable, but small states like Hawaii face even bigger challenges.

The size of smaller states' markets are small -- meaning there's less revenue from taxes -- but they face many of the same fixed costs in maintenance and technology as large states do. Also like their larger counterparts, states like Hawaii, Rhode Island and Vermont plus the District of Columbia can no longer depend on the federal grants they used to initially develop and fund their exchanges. The federal Centers for Medicare & Medicaid Services (CMS) prohibited using those grants toward operations starting earlier this year.

In statehouses over the next several months, debates will rage over how to fund exchanges -- but also whether those exchanges are worth maintaining at all, and in what form. The main source of revenue for state-based exchanges comes from fees paid by insurers. Most exchanges, though, are also still counting on at least some financial support from their general funds. California, which has the highest enrollment of any state, is one exception. The state can't use general revenue to fund its exchange, and is now running into an $80 million deficit that could require raising insurer fees from the current $13.95 per policy.

Hawaii

Like California, Hawaii's exchange director, Jeff Kissel, also wants to eventually depend exclusively on the exchange's own revenue -- in this case a 3.5-percent assessment on premiums that's in line with states in the federal exchange. But Kissel acknowledges that the exchange won't be able to run on that revenue alone -- even after the budget shrinks by 75 percent to $13 million -- until 2020 or 2022 using conservative-to-moderate enrollment projections.

In the meantime, Kissel is asking the legislature to give the exchange authority to take out $28 million in bonds and making the case that the market will come as the technology improves and

people become more familiar with the exchange. By 2022, Kissel expects to increase enrollment from 5 percent to 13 percent of the small-business market, 15 percent to 29 percent of the individual subsidies market, and attract higher-income earners and people from sovereign islands like Micronesia.

"If anything, our growth projections are conservative," Kissel said. "We've gone from a few hundred individuals and a handful of businesses to thousands [of individuals] and hundreds of businesses." The problem, he argues, were initial expectations that the exchange could stand on its own by 2015. "It's not immediately profitable, but it is sustainable. It was a mistake for anyone to think these would be profitable after their first year of service."

To be sure, there are doubters.

"We were so wrong about the numbers and deadlines [initially] that it's really hard to say now that we're definitely right," said Hawaii state Rep. Beth Fukumoto Chang. But while the House minority leader is reluctant to authorize the bond package, she's also hesitant to cede control to the federal government because of uncertainty with the King v. Burwell case before the U.S. Supreme Court that could strike down financial assistance in states that don't run their own exchanges.

Hawaii also has a more stringent employer mandate than the Affordable Care Act that's been in place since 1974. Kissel, Chang and some of her peers worry that switching to the federal exchange would complicate the state's ability to enforce that law.

One is Rep. Della Au Belatti, who chairs the state House's health committee and is sponsoring the bond bill. She said many lawmakers are leery of a general fund appropriation, but the bond idea has been tried before with other services.

District of Columbia

Broadening the tax base to more insurers or requiring more people to shop in the exchange are ideas Kissel's chief deputy said Hawaii consciously opted against. But one small exchange that has embraced it is D.C., which was second only to Hawaii in costs per enrollee last year. Much of the D.C. exchange's $28 million budget this year came from a 1-percent tax on virtually all health insurance policies in the District, in or out of the exchange.

The broader approach lowers the overall impact on insurance companies than fees, because going with that route would have produced fees of more than 15 percent, which would increase premiums for patients, the exchange's leaders argued. "Our size means we have to think differently than larger population states," wrote the exchange's director, Mila Kofman.

The D.C. plan was challenged by an insurance industry trade group last year, but a federal judge dismissed the case, arguing the Affordable Care Act granted state-based exchanges wide authority to fund operations. The group, however, is appealing the decision. A similarly far-

reaching tax hasn't been adopted elsewhere, but there is at least some interest among smaller states.

Rhode Island

Rhode Island is one of them. The state's exchange rollout has been considered one of the more successful in the country, but lawmakers -- particularly Republicans, who have repeatedly pushed bills to scuttle it -- are skeptical of ongoing budgets of at least $20 million.

The state is the only in the country that has yet to set any fees for insurers, but it's now considering a D.C.-style tax along with a host of other ways to save or raise money as the exchange's director figures out a budget for next year with the newly elected governor, Gina Raimondo, a Democrat who supports the exchange.

That bodes well for the exchange, considering the legislature is also overwhelmingly Democratic, but there's widespread sentiment that last year's budget of $23 million should come down significantly, and lawmakers want to minimize the use of state general funds, said Rhode Island state Rep. Joe McNamara, who heads the House's health committee. Even options such as linking up to the federal exchange like Oregon did or completely ditching state operations are at least valid for discussion, according to McNamara.

Vermont

Vermont is in a similar situation. The state already had one of the lowest uninsured rates in the country, which is also true of D.C., Hawaii and Rhode Island. But Gov. Peter Shumlin is proposing a $52 million budget that's not much smaller than last year's at a time when other states are dramatically cutting theirs, particularly as federal grant money and development costs recede. About $28 million of that would come from the state general fund, all while enrollment hasn't increased and could come in lower than last year's 38,000.

Unlike other states, Vermont requires small businesses to participate in its state exchange, so it towers over every other state with enrollment in that category (one Hawaii lawmaker is interested in exploring something similar). But that doesn't appear to provide enough money to limit dependency on the general fund.

A bipartisan group pitched a bill that would turn over IT functions to the federal government while maintaining regulatory control over plans in hopes of saving money and improving performance, which hasn't been as smooth as states like Rhode Island.

But state Rep. Shap Smith, speaker of the Vermont House, noted that switching to the federal exchange isn't free. Merging a state's existing Medicaid system with the federal exchange cost Nevada a reported $20 million, for instance, and Oregon paid a reported $4 million to $6 million for its transfer.

Beyond that, the uncertainty over whether Vermont could switch to the federal exchange and continue giving enhanced subsidies and credits to further bring down the cost of health policies

is unclear, Smith said. Unlike other states, Vermont offers additional assistance on top of federal subsidies. Lawmakers also don't want to switch to the federal exchange and risk losing subsidies altogether if King v. Burwell goes that way.

That puts the state in a similar boat as Hawaii and others: It's reluctant to move too soon but averse to spending more money. That could mean a delay in a more definitive decision on the future of the exchange, but Vermont lawmakers -- like others -- say their patience is limited.

"I think the sentiment is all over the board, and I think patience with the current exchange is wearing thin, and people are more willing to consider other options than they were previously," Smith said.

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