



Moving HealthSource RI Forward to the Feds

Implications of Moving RI's Health Exchange to Federal Control

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Executive Summary

Considering the transfer of the operation and ongoing funding of Rhode Island's health benefits exchange, HealthSource RI, to the federal government, this report finds:

- Governor Chafee's executive order establishing the exchange explicitly prohibits the use of general state funds.
- There is no other viable local funding source.
- There appears to be no legal barrier or other provision in the federal Affordable Care Act (ACA) barring such a transfer, and at least one other state is already cooperating with the federal government in this regard.
- There will be no loss of benefits to policyholders.
- The federal exchange operates at a much lower cost per enrollee.
- The state may need to return unspent federal funds but will not have to repay those that it has already spent.
- Rhode Island can achieve real budget savings.

The conclusion is that the State of Rhode Island and its insurance market is too small to support a costly state-run exchange.

Introduction

In 2011, after passage of the federal Patient Protection & Affordable Care Act (PPACA), the Rhode Island state legislature took up legislation to establish and operate a health benefits exchange, one of the three options available to states. This legislation passed the state Senate but did not come up for a vote in the House due to a conflict over abortion-related language.

Analysis of H7817, *a bill to turn health benefit exchange operations over to the federal government*

Rather than allow the federal government to establish and operate a health benefits exchange for Rhode Island, Governor Lincoln Chafee signed an executive order to establish the exchange in September 2011.¹ The order allowed the state to receive approximately \$104 million in federal grants for the planning, establishment, and early operation of what was ultimately named HealthSource RI.²

The exchange, which began operation on October 1 2013, has had a mixed record since opening. The technical issues that plagued the federal exchange and many other state exchanges were largely avoided in Rhode Island, and by that measure, it can justly be called a success. However, enrollment in private health insurance plans has failed to live up to projections and the stated goals of HealthSource RI's leadership and supporters.

As of March 31, 2014, approximately 28,000 Rhode Islanders had signed up for private plans through either the individual or SHOP exchange.³ This compares to projections of 81,000 by the end of 2014 from an analysis done by Dr. Jonathan Gruber⁴ and estimates of between 70,000 and 100,000 enrollees offered by HealthSourceRI Executive Director Christine Ferguson.⁵ These projections, compared with actual enrollment,

suggest that HealthSource RI is only achieving between 28 and 40 percent of its goals.

One potential bright spot has emerged from HealthSource RI: While they were given nearly \$104 million to plan, establish, and operate the exchange in 2014, organizers appear to have come in well under budget, and have only spent about \$46 million total as of March 1, 2014.⁶

Nonetheless, HealthSource RI has a major challenge going forward — how to fund the exchange. For fiscal year 2015 (beginning July 1, 2014), the exchange has a budget of approximately \$23 million.⁷ Roughly half of that can be paid for from unspent federal funds, which PPACA specifies can be used in 2014 to fund operations during the exchange's first year. Beginning January 2015, however, HealthSource RI needs to either find a new source of revenue or consider another option — returning the operation of the exchange to the federal government.

This analysis explains many of the challenges, opportunities, benefits, and costs connected with this second option, as well as reviewing several other options that have been proposed.

Alternative Funding Options

With an estimated budget of \$23 million for FY15, and presumably similar amounts in later years, HealthSource RI requires a consistent revenue source if it is going to continue to operate as a state-established exchange. The executive order by Governor Chafee establishing HealthSource RI explicitly rejects general funds as a revenue source and also rejects unspent federal funds:

13. Financial Accountability. The costs and expense of establishing, operating, and administering the RIHBE shall not exceed the combination of federal funds, private donations, and other non-state general revenue funds available for such purposes. No state general revenues shall be used for purposes of RIHBE, and no liability incurred by the RIHBE or any of its employees may be satisfied using state general revenues...

15. Prohibition on Diversion. Pursuant to Affordable Care Act S 1311(a)(3) and the prohibited uses of funds in the Funding Opportunity Announcement for a Cooperative Agreement to Support Establishment of State-Operated health Insurance Exchanges, federal grant funds received in the Fund shall not be diverted to activities unrelated to Exchange planning and establishment.⁸

There has been discussion that unspent federal funds could be used to fund HealthSource RI for all of Fiscal Year 2015 and possibly beyond, but Section 1311(d)5(A) of PPACA specifically prohibits federal funds from being used for operations after January 1, 2015, and requires exchanges to be financially self-sustaining.⁹

Even if HHS does elect to permit unspent funds to be used to fund operations, and the governor's executive order were modified to permit it, as well, PPACA is clear that no funds may be awarded after January 1, 2015, meaning this would be a vanishing revenue source.¹⁰

Others suggest that insurers or persons purchasing insurance policies through the exchange should bear the cost of HealthSource RI's budget. But the low enrollment compared to the high cost suggests that this would make policies on the exchange unaffordable, driving many out of the market and causing them to be uninsured.

For example, H7662¹¹ would assess insurers directly in proportion to the revenue they receive from policies sold on the exchange. But insurers would need to pass those costs on to policyholders. A \$23 million assessment would translate, at current levels of enrollment, to about \$821 a year per policyholder, or \$68 per month. It is important to note that this assessment cannot be reduced through exchange tax credits, meaning that policyholders would have to directly bear the full cost. For a family of three, this would mean an additional \$204 per month or \$2,448 for a year.

This additional cost would increase post-subsidy premiums for many Rhode Islanders by 50 to 100 percent, possibly more. For example, an individual with income of roughly \$23,000 has a maximum post-subsidy premium of approximately \$120 a month. Adding \$68 to that monthly premium would be a 57 percent increase.

It also would push the individual into the range where premiums exceed 8 percent of income. They would be exempt from the tax levied on people without health insurance, removing the PPACA's incentive mechanism for enrollment.

Grant requests submitted to the federal government by HealthSource RI indicate that administrators believe they have the power to assess insurers for the exchange's operating costs, bypassing the legislative process. If correct, the assessment would face similar problems in terms of raising the cost of insurance or healthcare (which would effectively be the same thing). Spreading the budget for HealthSource RI out over the entire insured population of Rhode Island, including employer-sponsored coverage, would impose a tax on employers and policyholders that drives premiums and costs higher throughout the state.

Another option is to simply raise taxes in Rhode Island. However, given the state's lackluster economic situation and a general consensus that high taxes in the Ocean State may be hindering growth, adding \$23 million in taxes on Rhode Island's residents and businesses would represent a poor policy choice.

The final option is that the state could use general fund revenue to support the exchange. The legislature could easily enact legislation overriding the executive order's prohibition on general funds. However, given that the state faces a budget deficit of \$150 million for FY15, expected to rise to \$419 million by 2019,¹² it will be a challenge for the state to find an extra \$23 million to fund HealthSource RI.

Legality of Turning Exchange Over to the Federal Government

The first question to be asked is whether it is even possible to turn the exchange over to the federal government to operate. While PPACA does not contemplate this option, there is little to suggest it cannot be done.

Section 1321 of PPACA gives the Secretary of Health & Human Services (HHS) broad discretion to set rules and regulations governing state-established exchanges as well as establishing the federal government's authority to establish and operate an exchange where the state has failed to do so.¹³ There is little doubt, especially given the legal flexibility that HHS has demonstrated in other matters to address various problems and issues created by the law, that the Secretary could simply establish rules and regulations governing the

transition of a state-established exchange to the federally operated exchange.

The strongest case for the legality of transferring the exchange to the federal government is that the federal government has already announced that it will accept the transfer of the Oregon exchange, which suffered catastrophic failure upon launch and was never able to enroll a single person end-to-end.¹⁴

In addition, two noted legal scholars on PPACA have been consulted on this issue, one an advocate and one an opponent of the law. Professor Nicholas Bagley, assistant professor of law at the University of Michigan Law School, and Jonathan Adler, Johan Verheij Memorial Professor of Law and Director of the Center for Business Law & Regulation at the Case Western Reserve University School of Law, have both been asked whether they are aware of any legal barrier to having a state turn over operation of a state-established exchange to the federal government. Both have stated their belief that there is no legal problem with this course of action.¹⁵

Loss of Benefits, Disruption as a Result of Transferring Exchange to the Federal Government

Under PPACA and regulations established by HHS and other federal agencies, exchanges established by the federal government differ little from those established by states. Section 1321, which would govern the Secretary's authority to take over Rhode Island's exchange, directs the Secretary to establish an exchange in states that is in compliance with all

laws, regulations, and requirements that state-established exchanges must meet.

Section 1321 also establishes that, when setting up a federal exchange for states that do not have their own exchanges, the Secretary does not have the authority to preempt any state law or regulation governing health insurance and related subjects.¹⁶ So the exact same benefits packages currently required by Rhode Island law, as well as the same regulatory structure that health insurers in the state must currently meet, would continue to be met under a federally run exchange for Rhode Island.

This means that Rhode Islanders' current plan selections will not be at all affected by the transition from a state-established exchange to a federally established exchange, nor will future offerings differ substantially from what is currently available (at least not as a result of the proposed transition).

For the average Rhode Islander, the only noticeable change will be that they go the Healthcare.gov Web site rather than HealthSourceRI.com to obtain coverage.

Because the exchanges established both by states and by the federal government are complex undertakings, legislation authorizing a transfer from state to federal control of Rhode Island's exchange will require serious discussion and cooperation between the governor's office and HHS, but with sufficient time and planning, the transfer should be able to be managed smoothly, with little or no disruption experienced by Rhode Islanders seeking coverage through the exchange.

Federal Online Exchange Capabilities

The severe technical issues that hindered the federal exchange's rollout as well as operations of many state-established exchanges are well understood. But by almost all accounts, the federal exchange now seems to be running smoothly, including processing 217,000 enrollees in the final day of the open enrollment period as well as several million visitors to the Web site.¹⁷

While this level of traffic did cause brief outages on Healthcare.gov in the closing days of open enrollment, the problems were fixed quickly. And as noted previously, the federal Web site is working well enough that its early technical problems apparently haven't been cited in Maryland or Oregon as a reason not to consider transferring their exchange operations to the federal exchange.

This is not to say the federal exchange is working perfectly. Recent news reports suggest that it is still having problems transferring Medicaid-eligible applicants to states for final processing,¹⁸ and the so-called "back end" of the system that reconciles enrollment with tax credits is, as yet, not built and functioning.¹⁹

But neither of these problems is a reason not to transfer Rhode Island's state-established exchange to the federal government. Rhode Island has managed significant enrollment through Medicaid to date, suggesting that any future enrollment through the federal exchange would be far smaller and more manageable. And the back-end function for calculating subsidy payments to insurers will be handled by the federal system regardless of whether

a state operates its own exchange or relies on the federal exchange.

In addition, HHS has more than six months to correct any existing problems and build any functionality that still is needed before the end of the year, something it presumably can handle with greater ease now that open enrollment is concluded.

Return of Funds — Spent and Unspent

As noted previously, Rhode Island had only spent about \$46 million of the \$104 million it had been awarded by HSS as of early March. Continued operation of the exchange through the end of 2014 will cause more of the available funds to be spent, but it is likely that HealthSource RI will end the calendar year with tens of millions of unspent federal dollars.

The language of PPACA does not specifically state that unspent funds must be returned to the federal government, but that is clearly implied by the limitations on funding awarded for the planning, implementation, and first year's operation. As a result, Rhode Island will need to return the excess funding to the federal treasury.

This is no different than if the state retains the state-established exchange, however, barring a decision by HHS to ignore the clear requirement that federal funds not be used beyond 2014.

It should also be noted that nothing has been found in the language of PPACA or in any of the grant requests submitted by Rhode Island guaranteeing continued operation of the exchange, conditioning funds on such a guarantee, or requiring the

repayment of already spent funds if the state fails to continue to operate the exchange. That is, dollars that have already been spent will not have to be returned.

Likewise, in all of the coverage of Maryland's and Oregon's consideration of closing down their state-established exchanges and allowing the federal exchange to take over, there is not a single mention of a state's being required to repay the funds that were already spent if it fails to continue operation of the exchange.²⁰

Regardless of whether Rhode Island maintains its current exchange or transitions to the federal one, the excess funds will most likely need to be paid. But there is no reason to believe that Rhode Island would be required to repay funds already spent.

Real Savings, Not Just Cost Shifting

One possible concern is that, in transitioning to the federal exchange, Rhode Island's citizens won't in the end save any money because the federal government will have to pay the same amount to add the state to the federal exchange. If this were the case, simply shifting the cost to the federal budget saves no money for Rhode Islanders, it just changes where they pay.

Fortunately, it is not the case that adding Rhode Island to the federal exchange would result in new costs anywhere near what the budget for HealthSource RI would be. This is simply a matter of scale — Rhode Island is a very small state in terms of population, with a limited number of customers to spread the costs over, while the federal exchange is very large and able to spread costs over a much bigger population.

According to press reports, the federal government expects to spend \$1.8 billion running the exchange in 2015.²¹ With approximately 7 million signups through the exchange as of March 31, 2014, that comes to approximately \$257 per enrollee in exchange operating costs, compared with \$821 for HealthSource RI. And the marginal cost of adding Rhode Island's carriers and population to the program are likely to be less than that.

Conclusion

The bottom line is that Rhode Island's insurance market is simply too small to support a state-run exchange without imposing devastating fees, taxes, assessments, or other levies on Rhode Island businesses, providers, and insured.

Rhode Island's legislature and elected executives have a choice between spending \$23 million in state funds for a reasonably well-run state exchange that facilitates Rhode Islanders in purchasing health insurance and signing up for Medicaid, or spending \$0 in state funds for a reasonably well-run federal exchange that facilitates Rhode Islanders in purchasing health insurance and signing up for Medicaid.

Rhode Island's elected leaders can vote to turn the exchange over to the federal government while preserving residents' ability to benefit from all of the protections, subsidies, and benefits, or they can vote to keep the state exchange with little to show for it except an additional \$23 million that must be found in an already tight budget.

For a state facing cumulative deficits of approximately \$1.16 billion between 2016 and 2019,²² the choice should be an easy one

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- ¹ Lincoln D. Chafee. Executive Order 11-09, “Establishment of the Rhode Island Health Benefits Exchange.” September 19, 2011. Available at: www.governor.ri.gov/documents/executiveorders/2011/Executive_Order_11-09.pdf (Accessed March 18, 2014.)
- ² Rhode Island Health Insurance Marketplace Grants Awards List, Centers for Medicare & Medicaid Services. Available at: www.cms.gov/CCIIO/Resources/Marketplace-Grants/ri.html (Accessed April 1, 2014.)
- ³ Charles Gaba. “Rhode Island: 3/31 Exchange QHP Total: 28K.” April 1, 2014. Available at: acasignups.net/14/04/01/rhode-island-331-exchange-qhp-total-28k (Accessed May 7, 2014.)
- ⁴ Dr. Gruber’s projections are found on page 2 of *Funding Opportunity Number: IE-HBE-11-004 CFDA: 93.525*, submitted by HealthSource RI. This number includes 19,000 that Dr. Gruber estimated would be in the Basic Health Plan, which was never developed but may be comparable to the Neighborhood Health Plan of Rhode Island insurance available to some Rhode Islanders via the exchange.
- ⁵ Amy Gallagher, *GoLocalProv*. “Smart Benefits: Will HealthSource RI Meet Enrollment Expectations?” September 30, 2013. Available at: www.golocalprov.com/business/smart-benefits-will-healthsource-ri-meet-enrollment-expectations (Accessed May 7, 2014.)
- ⁶ Erika Niedowski, *Associated Press*. “HealthSource RI: Talks about federal funds ongoing,” March 11, 2014. Available at: www.washingtontimes.com/news/2014/mar/11/healthsource-talks-ongoing-about-federal-funds (Accessed May 7, 2014.)
- ⁷ State of Rhode Island and Providence Plantations. “Fiscal Year 2015 Budget Proposal: Volume I — General Government, Quasi-Public Agencies and Component Units.” p. 74. Available at: www.budget.ri.gov/Documents/CurrentFY/BudgetVolumeI/0_Volume%20I%20-%20General%20Government,%20Quasi-Public%20Agencies.pdf (Accessed March 19, 2014.)
- ⁸ Executive Order 11-09 by Governor Lincoln Chafee, September 19 2011, http://www.governor.ri.gov/documents/executiveorders/2011/Executive_Order_11-09.pdf
- ⁹ Patient Protection and Affordable Care Act. Available at: www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf, p. 59-60
- ¹⁰ *Ibid*, Sec. 1311(a)4(B), p. 55 (Accessed May 7, 2014.)
- ¹¹ Relating to Health and Safety — The Rhode Island Health Benefits Exchange Funding Act, introduced by Rep. Spencer Dickinson, February 27, 2014. Available at: webserver.rilin.state.ri.us/billtext14/housetext14/h7662.pdf (Accessed May 7, 2014.)
- ¹² Governor’s Budget FY 2015 and 2014 Supplemental, p. 1, Senate Fiscal Office Report, March 6, 2014. Available at: webserver.rilin.state.ri.us/SenateFinance/budget_analyses/FY2015/FY2015%20Governor's%20Budget%20-%20SFO%20Analysis%20-%20FINAL.pdf (Accessed May 7, 2014.)
- ¹³ Patient Protection and Affordable Care Act. (See note 9.) p. 68

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- ¹⁴ Jeff Manning, “Cover Oregon: State Moves to Federal Exchange, but Oracle Technology Lives On,” May 6, OregonLive.com, available at: http://www.oregonlive.com/health/index.ssf/2014/05/cover_oregon_state_moves_to_fe.html.
- ¹⁵ Based on personal communications with each, both of whom were solely addressing the legality of such a move, not the wisdom or appropriateness of it. Professor Bagley specifically noted that while he thinks there are no legal issues, he does not endorse the idea.
- ¹⁶ Patient Protection and Affordable Care Act. (See note 9.) p. 68, Sec. 1321(d)
- ¹⁷ Charles Gaba, ObamacareSignups.com. “217,176 (Updated),” April 1 2014. Available at: <http://acasignups.net/14/04/01/217176> (Accessed May 7, 2014.); See also: *Kaiser Health News*. “Late surge in Obamacare signups, White House continues push.” March 30, 2014. Available at: [www.kaiserhealthnews.org/Daily-Reports/2014/March/29/obamacare-last-minute-signups.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:%20khn%20\(All%20Kaiser%20Health%20News\)](http://www.kaiserhealthnews.org/Daily-Reports/2014/March/29/obamacare-last-minute-signups.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:%20khn%20(All%20Kaiser%20Health%20News)) (Accessed May 7, 2014.)
- ¹⁸ Phil Galewitz, *Kaiser Health News*. “Thousands waiting for Medicaid coverage are stuck in limbo.” January, 6, 2014. Available at: www.kaiserhealthnews.org/Stories/2014/January/06/medicaid-enrollment-obamacare-exchange-marketplace.aspx (Accessed May 7, 2014.)
- ¹⁹ Jamie Duprie, *104.5 Newstalk WKOV*. “What's next on the Obama health law.” April 1, 2014. Available at: www.wokv.com/weblogs/jamie-dupree/2014/apr/01/whats-next-obama-health-law (Accessed May 7, 2014.)
- ²⁰ Nick Budnick. (See note 14.) It is possible that, as a result of possible fraud committed by certain of Oregon’s public officials, contractors, vendors, and others, the state of Oregon may have to repay some of the spent funds received from the federal government to establish their exchange. But this is a far different situation than in Rhode Island and would exist even if Oregon continues to operate its exchange.
- ²¹ Paul Demko, *Modern Healthcare*. “Healthcare providers oppose Medicare cuts in Obama's 2015 budget.” March 4, 2014. Available at: www.modernhealthcare.com/article/20140304/NEWS/303049971 (Accessed May 7, 2014.)
- ²² Governor’s Budget Fiscal Year 2015, Executive Summary, p. 217. Available at: www.budget.ri.gov/Documents/CurrentFY/ExecutiveSummary/0_FY%202015%20Executive%20Summary.pdf (Accessed May 7, 2014.)