FINANCIAL SUSTAINABILITY OF THE ALABAMA EXCHANGE

ALABAMA DEPARTMENT OF INSURANCE

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Robert L. Carey
RLCarey Consulting

LMI

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The financial resources needed to plan, implement, and operate the Alabama Exchange during the first year of operations—which commences with open enrollment in October 2013 and runs through the end of December 2014—will be provided by the federal government through cooperative agreements administered by the Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services. In accordance with the Patient Protection and Affordable Care Act (ACA), a state "…shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."[1] By January 2015, Alabama—and all other states that choose to operate an Exchange—will need to establish a funding mechanism to support Exchange operations.

The recently released notice of proposed rulemaking, which was issued by CCIIO in July 2011, gives the states flexibility in choosing how to finance their Exchanges. That notice included the following:

> States may use other forms of funding for Exchange operations, consistent with the reference in section 1311(d)(5)(A) that allows States to 'otherwise generate funding.' This language provides States with broad flexibility to generate funds beyond charging the 'assessments or user fees' identified in the statute. States may use broad-based funding (which may include general State revenues, provider taxes, or other funding that spreads costs beyond imposing assessments or user fees on participating issuers), as long as the use of such funding does not violate other State or Federal laws.[2]

Alabama will need to develop a financial sustainability plan well in advance of January 2015. To receive additional federal funding to support the development and initial operations of the Exchange through December 2014, Alabama must include a financial sustainability plan in its multi-year funding request (i.e., a

[1] Section 1311(d)(5)(A) of the ACA.

[2] Department of Health and Human Services, 45 Code of Federal Regulation, Parts 155 and 156, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," page 41874.

Level Two Cooperative Agreement) that will need to be submitted to CCIIO by either March 30, 2012, or June 29, 2012.

The purpose of this report is to document some of the material in that financial sustainability plan. In the report, we identify the key variables that will affect the financial sustainability and the overall budget of the Exchange; review how the two existing public Exchanges are financed; and discuss funding options available to Alabama.

FACTORS AFFECTING THE EXCHANGE BUDGET AND FINANCIAL SUSTAINABILITY

Several key factors will affect the budget of the Exchange and the resources required to support its operations. The most important factor affecting the Exchange's financial requirements is the actual number of people who enroll in coverage through the Exchange, including both the individual and small group markets. Other key factors include the ability of the Exchange to leverage existing infrastructure, both from public entities and the private sector, to support operations and provide services for Exchange customers; and the extent to which Alabama gives the Exchange an active role in billing, collecting, and remitting premiums in the individual market. We discuss these and other key factors in the following subsections.

Enrollment

The projected enrollment through the individual Exchange and small business health options program (SHOP) Exchange will significantly affect the Exchange's operating budget and financial sustainability plan. We estimate that as many as 380,000 Alabamians may be eligible for advance premium tax credits and another 120,000 residents could purchase coverage (unsubsidized) through the Exchange, for a total potential pool of approximately 500,000 residents. These estimates comprise the total potential pool of enrollees in the individual Exchange. For budgeting purposes, we selected three different participation rates for the individual market Exchange: low (40 percent of potential enrollees); moderate (60 percent of potential enrollees); and high (80 percent of potential enrollees). Table 1 shows the results of these participation rates.

Table 1. Enrollment Estimate—Individual Exchange

Enrollment estimate	Percentage of eligible members	Estimated membership
Low enrollment	40	200,000
Moderate enrollment	60	300,000
High enrollment	80	400,000
Total potential pool	100	500,000

In addition to the individual market, some portion of the small group market could purchase coverage through the SHOP Exchange. We estimate that approximately 600,000 people[3] are currently receiving coverage through Alabama's small group market. We recognize that some uninsured employees of small firms may seek coverage through either the individual or SHOP Exchanges, but for the purpose of these enrollment and cost estimates, we do not assume any additional uptake by these uninsured workers in the SHOP exchange. Two key assumptions affect the estimates of SHOP Exchange enrollment: (1) the current definition of small employers (2 to 50 employees) is not altered prior to 2016; and (2) the number of people covered in the small group market remains relatively unchanged. The first assumption is under the direct control of Alabama policymakers, while the second will be driven by the annual increase in health insurance premiums and the condition of the economy in Alabama, among other factors. However, because employer premium tax credits will only be available to eligible small employers that purchase coverage through the Exchange for the first 2 years, some small employers may have a financial incentive to use the Exchange as the distribution channel for their employees' health insurance.

Our estimates of enrollment through the SHOP Exchange (see Table 2) are materially lower than the potential enrollment in the individual Exchange because of the lack of premium subsidies, with the exception of the 2-year employer subsidy available to employers with low-wage workers. Furthermore, at least initially, small employers may be less likely to switch from their current source of coverage and utilize the Exchange. As examples, enrollment in the Utah Exchange and the Massachusetts Connector's small group Exchange show that modest numbers of employees are using these Exchanges to purchase coverage. As of October 1, 2011, Utah reported that 182 groups covering roughly 4,600 members (i.e., employees, spouses, and dependents) were insured through its Exchange. The Massachusetts Connector, through July 2011, reported fewer than 2,500 employees of small employers were covered through the Connector, representing less than 0.5 percent of the entire small group market (approximately 750,000) covered lives in Massachusetts.

Table 2. Enrollment Estimate—SHOP Exchange

Enrollment estimate	Percentage of eligible members	Estimated membership
Low enrollment	1	6,000
Moderate enrollment	5	30,000
High enrollment	10	60,000
Total potential pool	100	600,000

[3] Not all people working in Alabama and receiving health insurance through an Alabama small employer are residents of Alabama. The number cited is an estimate of those people who receive coverage from an employer located in Alabama.

Eligibility

The manner by which eligibility for coverage through the Exchange will be coordinated with the state Medicaid agency is a key decision for the state and a major cost center for the Exchange. The establishment of a single, streamlined eligibility determination process for all medical assistance programs, including Medicaid, ALL Kids (the state's Children's Health Insurance Program), and the Exchange, will be a major challenge for the state. If the state's Medicaid agency uses Medicaid's eligibility system to determine eligibility for advance premium tax credits and health coverage through the Exchange, it will incur costs to handle this added caseload. In addition to the information technology upgrades and infrastructure needed to adjudicate eligibility for thousands of Exchange enrollees, the agency will need to process applications and respond to appeals and inquiries.

For the purpose of this budget estimate, we project that the cost to administer the eligibility process for the Exchange will be approximately $15 to $20 per enrollee per year. This estimate includes the costs for determining eligibility, notifying applicants, adjudicating appeals and responding to inquiries, and transferring eligibility files to the Exchange. The estimate does not include the potentially significant expenditures for modifying and enhancing the state's current eligibility system. Those costs, it is presumed, will be largely covered by the federal government through Exchange establishment grant funds (100 percent federal) that will be available through the end of 2014 and enhanced Medicaid matching funds (90 percent federal, 10 percent state).

Health Plan Enrollment Systems

The development and maintenance of an infrastructure that will allow people to shop for insurance, compare health plans, and enroll in coverage will likely be the single largest ongoing expense for the Exchange. The services and resources needed to assist residents as they purchase coverage through the Exchange will include a web portal, health plan comparison and decision support tools, call center and consumer assistance program, health plan premium rating engine, enrollment process, exchange of information with carriers and the federal government, premium billing, collection and remittance, and ongoing account management.

Numerous private-sector vendors provide these types of services, and other firms are in the process of developing systems designed to handle all facets of the consumer shopping experience and the enrollment of individuals and small employers into qualified health plans. Exchanges in Florida (Health Choices), Utah, Connecticut (Health Connections), and Massachusetts are using private firms to handle the myriad health plan enrollment administrative requirements.

Based on market research, we believe that it may be possible to engage vendors with minimal upfront investment on the part of the Exchange, with contracts that use a per member per month fee schedule. However, the Exchange may want to use federal funding that will be available through 2014 to pay for the initial

capital investments to reduce the ongoing monthly charge. If the Alabama Exchange chooses to rent the infrastructure and resources needed to support health plan enrollment—including health plan comparison tools, premium rating engine and cost calculator, enrollment systems, call center and consumer assistance, account management, and premium billing, collection and remittance, among other related services—it will still need to pay for contract employees, software licensing fees, maintenance, and upgrades.

Depending on the types of functionality required and the level of consumer assistance provided, the Exchange's upfront investments could range from $10 million to $15 million. Charges for ongoing maintenance—assuming a fully outsourced health plan enrollment system, including premium billing and collection—could range from $6 to $10 per member per month. This monthly fee could be reduced through volume discounts.

The Exchange's ongoing costs could be further lowered if it elects not to be actively involved in premium billing and collection on behalf of consumers purchasing coverage in the individual market. A key decision for the Alabama Exchange will be the extent to which it assumes responsibility for billing individual market enrollees, collecting the federal subsidy for enrollees who are eligible for an advance premium tax credit, and aggregating the premiums on behalf of the carriers. If the Exchange requires carriers to handle this responsibility, the Exchange's per member per month costs could be reduced by up to 50 percent; with ongoing maintenance costs ranging from $3 to $5 per member per month.

If the Exchange chooses not to assume responsibility for premium billing and collection in the individual market Exchange, the SHOP Exchange would still need to aggregate premiums for employers that purchase coverage in the small group market. As noted above, given the relatively lower number of small group purchasers—compared to consumers purchasing coverage in the individual market—the cost to the Exchange to service these customers should be relatively modest.

Outreach and Marketing

Instituting an aggressive outreach and education campaign will be critical to generating sufficient enrollment in the Exchange. The availability of premium subsidies and reduced cost sharing for health plans purchased through the Exchange will undoubtedly provide a significant advantage over other commercial insurance distribution channels. However, it is important to recognize that people will need information on their health insurance options, their responsibility to obtain and maintain health coverage pursuant to the individual mandate (assuming the mandate is not found unconstitutional or otherwise changed), and the subsidized health insurance that may be available to them.

If the Exchange is to attract sufficient volume, it will need to undertake a multipronged outreach, education, and enrollment campaign. Such an effort could include Exchange employees; coordination with social service agencies, such as the

Department of Public Health, Medicaid, and county governments; schools-based promotional activities; community and faith-based advocacy organizations; private employers; business groups; hospitals, community health centers, physicians, and health insurers; paid media; and public-service announcements.

The health reform law requires the Exchange to provide grants to "navigators" that apprise people of their health coverage options and help individuals enroll in an Exchange health plan or in other publicly subsidized health coverage programs. Navigators are entities, such as trade, industry, and professional associations; chambers of commerce; unions; community-based, non-profit groups; and other groups that have established or can readily establish relationships with employers, employees, consumers, and self-employed individuals.

Navigators are responsible for conducting public education activities to raise awareness of the availability of qualified health plans through the Exchange; distributing "fair and impartial" information concerning enrollment and the availability of premium subsidies and cost-sharing reductions; facilitating enrollment in qualified health plans; referring people to the appropriate agency or agencies if they have questions, complaints, or grievances; and providing information in a culturally and linguistically appropriate manner.

The initial outreach, education, and enrollment activities—including funding for the navigators—requires an upfront investment by the Exchange, even before anyone enrolls in coverage. We estimate that the annual cost for outreach and enrollment will range from $3 million to $5 million, including media buys and support for community-based outreach and education, such as navigators.

Exchange Staff

Alabama will need to hire employees to operate the Exchange and oversee the contracts with the various vendors that will probably perform most of the day-to-day operations. A lean operation with minimal staff would likely require 25 to 30 employees, including an executive director, operations manager, chief information officer, outreach and marketing coordinator, finance director, legal counsel, contract managers, policy analysts, and associated support staff. We estimate that the annual cost of staffing the Exchange will be $2.5 million to $3.0 million. In addition, the cost of facilities and supplies, including rent, furniture, and computers, will cost another $200,000 to $400,000 per year.

TOTAL ESTIMATED BUDGET

Table 3 provides a high-level summary of the potential cost to operate the Alabama Exchange. This summary, which does not include the cost of upfront investments funded by the federal government, could be used to drive the financial sustainability model for operation of the Exchange in 2015 and beyond. The budget estimates for ongoing operations of the Exchange range from $34 million

to $49.6 million, which equates to a cost range of $8.98 to $13.76 per Exchange member per month.

Table 3. Exchange Administrative Cost Estimate—Calendar Year 2015

Budget category	Estimates: 2015		
Enrollment Individual and SHOP	Low: 206,000	Medium: 330,000	High: 460,000
Eligibility determination			
Annually per enrollee	$17.50	$17.50	$17.50
Annual total	$3,605,000	$5,775,000	$8,050,000
Health plan enrollment			
Monthly per enrollee	$10.00	$8.00	$6.00
Annual total	$24,720,000	$31,680,000	$33,120,000
Outreach and marketing	$3,000,000	$4,000,000	$5,000,000
Exchange staff	$2,500,000	$2,750,000	$3,000,000
Facilities	$200,000	$300,000	$400,000
Total estimated cost			
Annual total	$34,025,000	$44,505,000	$49,570,000
Monthly per enrollee	$13.76	$11.24	$8.98

FUNDING OF EXISTING EXCHANGES

The two public Exchanges currently operating, Utah and Massachusetts, both charge a fee to consumers that purchase coverage through the Exchanges.

Utah assesses a $43.00 per subscriber[4] 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 to brokers and $6.00 to the Exchange, which is used primarily to facilitate enrollment and aggregate 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 Exchanges required by the ACA. In particular, Utah's Exchange does not sell insurance to individuals, does not offer premium subsidies, and therefore does not determine eligibility for subsidized coverage.

[4] 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 Massachusetts Connector Exchange retains 3.0 percent of monthly premiums (roughly $12.00 per subscriber) to fund its administrative costs. Unlike the Utah Exchange, it also sells subsidized and unsubsidized health insurance to individuals, as well as offering (unsubsidized) health insurance to small employers. Although there are some meaningful differences between the Massachusetts Connector and the federal Exchange, the federal requirements of an Exchange are modeled largely after the Massachusetts Connector.

OPTIONS FOR ALABAMA

The basic options for funding the Alabama Exchange beginning on January 1, 2015, which we outline below, can be used exclusively or combined. The Exchange's primary responsibility will be facilitating the enrollment of individuals and employees into health coverage, and serving as an access point for individuals and families eligible for advance premium tax credits and cost-sharing reductions. However, the Exchange will have broader responsibilities that extend beyond the distribution of insurance. These responsibilities include reviewing applications for, and granting exemptions to, the individual health coverage mandate; facilitating the enrollment of individuals into Medicaid and ALL Kids programs; and providing information on all health plans and health insurers operating in the Alabama individual and small group markets.

Fee Assessed to Consumers

The Exchange could assess a fee on consumers that purchase coverage through the Exchange or on every policy sold in the state inside or outside the Exchange. This fee could be structured as a percentage of premium or a flat rate. If the fee is added to the monthly premium, as opposed to being embedded within the monthly premium, it would probably affect the affordability of coverage since if the fee was added on top of the member's share of the premium, the actual cost to the member would increase. However, if the fee is embedded in the premium, those who receive subsidies would not have to absorb the full cost of the fee. In addition, an add-on fee could put the Exchange at a competitive disadvantage vis-à-vis other distribution channels, particularly for those consumers who are not eligible for premium subsidies.

Fee Charged to Health Insurance Plans

This fee could be assessed as a percentage of the total health insurance business that a carrier has within the state. The fee could be structured so that it does not affect the insurer's medical loss ratio (MLR), and therefore not impact the insurer's MLR requirements. Alabama could choose to apply the fee to all carriers issuing policies inside and outside the Exchange, or apply the fee only to the health plans that are sold through the Exchange.

Tables 4 and 5 display the estimated cost per enrollee per month, as well as the estimated cost per subscriber per month. An enrollee is an individual covered by the health plan, while a subscriber is the policyholder. For example, a parent that purchases a health plan is a subscriber (as well as an enrollee), whereas a child covered under a parent's health plan is an enrollee. For the purpose of this report, we assumed two enrollees per subscriber.

Table 4. Exchange Financing Options—Fees Applied to Exchange Enrollees Only

	Low estimate	Medium estimate	High estimate
Estimated Exchange enrollment (members)	206,000	330,000	460,000
Total estimated administrative costs	$34,025,000	$44,505,000	$49,570,000
Estimated monthly cost per enrollee	$13.76	$11.24	$8.98
Estimated monthly cost per subscriber (2 enrollees per subscriber)	$27.52	$22.48	$17.96

Table 5. Exchange Financing Options—Fees Applied to All Individual and Small Group Enrollees

	Low estimate	Medium estimate	High estimate
Estimated Exchange enrollment (members)	206,000	330,000	460,000
Estimated non-Exchange individual and small group enrollment (members)	826,000	826,000	826,000
Total estimated individual and small group enrollment (members)	1,032,000	1,156,000	1,286,000
Total estimated administrative costs	$34,025,000	$44,505,000	$49,570,000
Estimated monthly cost per enrollee	$2.75	$3.21	$3.21
Estimated monthly cost per subscriber (2 enrollees per subscriber)	$5.50	$6.42	$6.42

Note that the total administrative costs calculation outlined above assumes that the Exchange will be responsible for collecting the premium from the insured and the insured's subsidy from the federal government for the individual Exchange. If the Exchange elects not to perform this function, total administrative costs could drop considerably. We anticipate the monthly health plan enrollee cost to range from $3–5, rather than $6–10. This would result in estimated annual costs ranging from $21.7 to $33 million rather than $34 to $49.6 million based on enrollment level.

CONCLUSION

While this analysis provides high-level estimates of the cost of operating an Exchange in Alabama, many details of the Exchange functions must be determined before more precise estimates can be made. The actual number of enrollees will significantly drive the costs as well. The State of Alabama must balance the extent of functions performed by the Alabama Exchange with the costs resulting from these functions. Ultimately, a major advantage of operating a state Exchange is to increase and promote competition within the health insurance market. If enrollees bear large administrative fees for purchasing within the Exchange, they may be less likely to participate in the Exchange.