

FOUNDATION FOR GOVERNMENT ACCOUNTABILITY

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Chairman Gallison and members of the Finance Committee.

Thank you for allowing me the opportunity to testify. My name is Josh Archambault, and I am a Senior Fellow at the Foundation for Government Accountability (FGA), a non-partisan think tank focused on health care and welfare issues at the state level.

While FGA is located in Florida, I am based in Boston, and have spent nine years studying the successes and failures of the 2006 Massachusetts health reform law (Chapter 58 of the Acts of 2006) commonly called “RomneyCare.” My research has often focused specifically on the state-based exchange, called the Connector in the Bay State.

In that light, I come today to share with you some of my thoughts on H. 7817 “The Rhode Island Health Benefits Exchange Act.”

I would like you to takeaway three overarching messages when considering whether to advance this bill:

- 1) Rhode Island officials join numerous other states facing the fiscal reality of paying to keep the doors open at a state-based exchange with lower than expected enrollment.
- 2) Keeping the doors open for HealthSource RI will have unintended consequences and therefore must demonstrate a good return on investment and added value to the marketplace to justify additional taxpayer money.
- 3) Funding questions that surround HealthSource RI do not take place in a vacuum, as the Affordable Care Act (ACA) adds other state budgetary considerations to this discussion. For example, the previously eligible but not enrolled “woodwork” Medicaid population will add \$55-100 million dollars to the Rhode Island state budget *every year*.

Rhode Island Officials are not alone in Thinking about Switching to the Federal Exchange

Following the news of the federal government taking over the now-defunct Oregon exchange¹, Nevada defaulting² to healthcare.gov, and now Massachusetts contemplating defaulting³ later this year for massive technical issues, the Ocean State is now facing the next round of concerns over state-based exchanges: finances.

After Oregon, Nevada, Massachusetts, officials in states as diverse as Hawaii, Maryland, Minnesota and Colorado are all facing tough questions about keeping their state-based exchange.

Also of note are the many “partnership-exchange” states, those primarily relying on Healthcare.gov, that have shelved plans to open state-based exchanges: Delaware, Illinois, Iowa, Michigan, New Hampshire, New Mexico and West Virginia.

Rhode Island's Exchange has been very Costly, and Will Remain so in the Future

Governor Lincoln Chafee (D-RI) implemented a state exchange (HealthSource RI) by executive order in September 2011.⁴

The executive order enabled the state to apply for \$163 million⁵ in federal exchange grants (of which you have received more than \$114 million). This amounts to roughly \$4,002 per enrollee, while the federal exchange averaged an approximate per-enrollee cost of \$647.

However, it has been reported that Rhode Island has only spent \$46 million of its establishment grants. Under this scenario, the cost per enrollee still runs 2.5x more (\$1,615) versus the cost of the federal exchange.

It is my opinion that the remaining unspent federal money should be returned, as it was only intended for the planning and early establishment of the exchange.

Tradeoffs for Future Cost of Running HealthSource RI

Former Rhode Island Secretary of Health and Human Services Gary Alexander laid out the budgetary issue in a recent op-ed in the *Providence Journal*⁶:

...according to the governor's 2015 budget, \$23 million [is needed] annually to operate and maintain HealthSourceRI, the state-based insurance exchange. That's not \$23 million to help low-income residents purchase health insurance; it's \$23 million in overhead that would have been unnecessary had the Ocean State decided, as 27 states have done, to rely on the federal exchange. These other states use the federal portal and pay nothing.

Now, \$23 million is a lot of money for a small state like Rhode Island. It's more than we spend to run the Division of Motor Vehicles, three times what the state budget appropriates for public libraries, and twice the amount needed to pay this year's installment of the 38

Studios bonds. If returned to our cities and towns, that \$23 million would increase total local aid by 20 percent. That amount could also be allocated to reduce property taxes or the sales tax or buy a new computer system for the DMV. Or reduce by almost a sixth the projected \$151 million 2016 budget shortfall.

For context, Rhode Island, a state with a population of 1.05 million, is looking to spend at least \$23 million a year, while Massachusetts, a neighboring state with a population six times as large, has run an exchange with enrollment more than 6 and half times higher with an annual budget of around \$35 million. Yet still, the Massachusetts exchange has been a questionable experience from a return on investment perspective.

As Rhode Island is currently dealing with the fallout of a failed \$75 million⁷ loan to former MLB pitcher Curt Schillings' company 38 Studios, at least in that deal there was a slight chance of repayment. State funds being spent to support HealthSource RI will only be money out the door.

Federal Funds cannot be pushed to Future Years

The recent announcement that the federal government will allow HealthSource RI to carry over some of the exchange grant funds to 2015⁸, appears to be in direct conflict with the Governor's original executive order establishing a state-based exchange.

In Chafee's original executive order, he explicitly prohibited state funds from being used to fund future operation or the diversion of unused federal money:

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.

Putting aside for a minute this foundational conflict, it is important to remember, it doesn't change the underlying issue of sustainability. When federal funds run out, states still have to pay for the exchange whether that starts in 2015, 2016, or 2017. Rhode Island would be wise to deal with the cost question now, before spending hundreds of millions more and then switching directions.

There are Numerous Unintended Consequences of Keeping HealthSource RI Afloat

Rhode Island has three options for financing a state exchange going forward:

Assess only those in the exchange. In many states, applying a surcharge on every plan written *within* the exchange has financed operations. However due to low enrollment in Rhode Island, this option would be significant in cost.

Given the current enrollment levels in HealthSourceRI, if the cost of running the exchange fell solely on their shoulders, it would cost roughly \$70 per member per month. For a family of four, that would add \$3,360 directly to their premiums. This is especially burdensome for low-income families.

Assess everyone with insurance in the state. This is the direction that the exchange in DC and Washington state have taken, and is also being debated in Hawaii and Colorado. However, this path is unfair for those not utilizing the exchange, will increase insurance premiums for all residents of the state and will lead to moral hazard and possible poor customer service as Health Source RI will receive revenue regardless of their performance.

Tax all taxpayers in the state. The state could raise taxes, but this will be politically unpopular and harmful to economic growth, especially in struggling states like Rhode Island where unemployment is already high.

If Rhode Island keeps HealthSource RI open, the consequences could be significant:

Exchange Spending Crowds-Out Spending on other Priorities

Every general fund dollar spent to operate HealthSourceRI is one less dollar available for education, public safety, infrastructure and other public priorities in the state. This crowd out occurs regardless if it is state or federal funds.

Since states have to balance their budgets, fiscal prudence is needed. Running a state-based exchange may not be justified. Advocacy and single-issue groups of all stripes should be united against a state-based exchange, as it will draw more funds away from their projects.

What Value does a State-Based Exchange add?

Given all the rules and regulations placed on state-based exchanges by the Obama administration, many states have struggled to find how they can add value to their market.

This was often the reason cited by states that decided against a state-based exchange to begin with. It should be noted that Arkansas is the only state to consider opening a new state-based exchange in the near future, but that will be at least another two years from now and remains an open question.

Contrary to Conventional Wisdom, Massachusetts' Exchange has Struggled

The experience in Massachusetts is revealing. After seven years of operation, the Connector (the name of the Massachusetts exchange) has struggled to attract unsubsidized business. In a state of 6 million lives, with a small group market of well over 635,000 lives, the Connector has attracted a grand total of 5,000 small business lives, less than .7 percent of the potential market.⁹ The vast

majority of their customers have been those on subsidized coverage with only one choice for where to redeem their subsidy, the Connector.

This low enrollment trend is backed up by the early enrollment¹⁰ experience here in Rhode Island. In fact, one Rhode Island insurer is already making plans¹¹ to set up its own private exchange for businesses, given the low interest and participation from the business sector with the public exchange. Similarly, a private exchange in Massachusetts has done very well competing with the public exchange in the Bay State at a fraction of the cost to operate.

Exchange Costs are Just the Tip of the ACA Iceberg

The exchange expenses do not occur in a vacuum. States like Rhode Island that have expanded Medicaid and rebuilding eligibility systems face daunting additional budget pressure in the near term.

According to WPRI reporter Ted Nesi, the state is facing a ballooning Medicaid budget: “Under the new projections, Rhode Island’s total annual spending on Medicaid will rise from \$1.6 billion in the 2012-13 budget year to \$2.3 billion in 2014-15, an increase of \$729 million in just two years. The number of people on Medicaid totaled 246,193 last month, up from 198,085 a year earlier.”¹²

This is after 64,590 people signed up for Medicaid in the state as of March 31st. Nesi, in a separate post, notes “That’s far more than what state officials had forecast, which was for 28,000 Medicaid sign-ups by Sept. 30 and 51,000 by March 2015.”¹³

In addition, as 34 percent (roughly 22,000) of the new Medicaid enrollees were previously eligible but not signed up, Rhode Island will have to pay for 50 percent of their coverage and additional administrative costs and will not receive an enhanced federal match for that population.

The Medicaid woodwork population will cost Rhode Island every year between \$55-\$103 million in additional funds. This additional cost is over and above any cost associated with the decision to expand Medicaid in the state. (This estimate assumes a 50 percent match rate. It would be \$55 million if all new enrollees cost as much as the average adult at \$5,000 per year [in Rhode Island](#)¹⁴, or \$103 million if all new enrollees cost the average for the entire Medicaid population in 2012 of \$9,369.¹⁵)

The cost of Medicaid is only likely to grow. The program does not maintain open enrollment periods similar to the exchanges, and many individuals eligible for Medicaid can sign up anytime during the year.

The cost of this woodwork population, along with the surge in additional spending required to cover the state's growing Medicaid population of able-bodied adults, will undeniably hurt the most vulnerable.

Rhode Island has already started to buckle under the financial pressure of Medicaid costs. Felice Freyer at *The Providence Journal* has reported that in his budget this year the Governor has asked for cuts to the Medicaid program.¹⁶ This includes “scaling back payments to hospitals, nursing homes and the private insurance companies that manage the care of most Medicaid recipients” and introducing a \$250-a-month premium for parents of disabled children. This tracks similar pre-ObamaCare Medicaid expansion experiences in Maine, Oregon and Arizona.¹⁷

Finally, another expensive ObamaCare-related cost that many states have taken on. The massive eligibility-determination system in Rhode Island, called the unified health infrastructure project, is slated to cost \$209 million, requiring \$51.3 million+ in state money by 2020.¹⁸ These added expenses make it even more unpalatable to finance a state-based exchange and are redundant for eligibility determination if a state uses healthcare.gov.

Many Other States have Exchange Issues like Rhode Island

Nevada: The problems¹⁹ with Nevada's exchange are deep. In a recent Deloitte report²⁰, more than 1,500 defects were identified, with more than 500 deemed high severity. In addition to low enrollment, the governing Board has just voted to default to healthcare.gov.

Hawaii: According to McKenna Long & Aldridge, “the Hawaii legislature approved \$1.5 million in state funding to support the Hawaii Health Connector, which had originally requested \$4.7 million from the state to help fund its operations.”²¹ The Hawaii exchange has the highest cost per enrollee in the entire country and the future of the exchange is extremely uncertain.²²

New Mexico: McKenna Long & Aldridge has also been tracking the developments in New Mexico. The state recently put out request for public comment on its funding options moving forward.²³ “To pay for its estimated \$24 million annual budget, the New Mexico Health Insurance Exchange is considering using market-wide assessments on carriers, exchange carrier assessments and/or administrative fees.”

Minnesota: A January report shows that the website is still suffering from more than 200 defects and a debate has started to determine how to finance operations going forward. According to Atlantic Information Services, “Minnesota's exchange, which is required to charge 1.5 percent premium tax on all private plans, might need to boost that percentage to reach the \$58.1 million it needs to be self-sustaining.”²⁴

All the exchanges set up as government entities (e.g. Kentucky, New York, Rhode Island, Vermont and possibly Hawaii) face a similar political debate over whether state financing should be utilized.

Maryland: The state has already spent an additional \$5 million of general funds to support its exchange.²⁵ Even with its recent decision to spend \$40 million to buy software from Connecticut, the federal government might sour on Maryland's track record, as the feds previously "invited" the state to join healthcare.gov.²⁶

Colorado: Officials in Colorado are struggling to figure out a financing structure going forward.²⁷ There is little interest in a broad-based tax or fee increase and the governing Board has voted down increasing the fees inside the exchange. This debate could result in a stalemate and officials might have to consider alternatives in future years.

Massachusetts: The state will spend over \$500 million dollars, and are very likely to default to Healthcare.gov next year, as a brand new contractor is being hired to stand up a functional exchange in five months, a task the state failed to do alongside CGI over a 3 and half year period.²⁸

Oregon: After spending \$200 million+ on a failed website, the state will be defaulting to healthcare.gov shortly.²⁹

Conclusion

The future of state-based exchanges are not bright. Officials need to think long and hard about the unintended consequences that come from spending additional taxpayer money, or passing on the cost of operations to residents in the state, just to keep the lights on at an entity that has drawn limited interest from those that have a choice of where to purchase insurance. Thank you for your interest and attention.

Biography:

Josh Archambault is a senior fellow at the Foundation for Government Accountability.

Prior to joining FGA, Josh served as the director of the Center for Healthcare Solutions and as program manager for the Middle Cities Initiative at Pioneer Institute, a Boston-based free-market think tank.

While at Pioneer he co-authored the nationally acclaimed book [The Great Experiment: The States, The Feds, and Your Healthcare](#) (2012) and published numerous studies on the potential impact of payment and delivery system reform proposals on patients and the ACA's impact on residents and businesses. Past research has also concentrated on the lessons that could be learned from the Massachusetts health care experiment.

He has testified before several state legislative committees and before the U.S. House of Representatives' Committee on Energy and Commerce's Subcommittee on Health.

Josh's work has earned coverage in outlets including the Wall Street Journal, USA Today, The New York Times, Fox News, NPR, Money Magazine, and National Review Online. He is also a regular contributor to the Forbes.com blog, The Apothecary.

Josh holds a master's in public policy from Harvard University's Kennedy School of Government and a B.A. in political studies and economics from Gordon College.

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