

Comments are being requested on this draft White Paper on or before March 18, 2011. Comments should be sent only by email to Jolie Matthews at jmatthew@naic.org.

Financing the Exchange

I. Introduction

For each fiscal year, the Secretary of the United States Department of Health and Human Services (HHS) shall determine the total amount that will be made available to each State for grants to start an exchange.¹ However, in establishing an exchange, the 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.² Depending on the size of the state, the utilization and capabilities of the exchange, costs are anticipated to range from a few million to in excess of \$50 million.

This paper contemplates various financing mechanisms for states to consider as they move toward establishing a health insurance exchange. It both contemplates assessments, user fees and other potential sources to generate funding to support exchange operations. Since the majority of states are still in the infancy phase of planning and forming policy to establish an exchange, a wide variety of options have been provided. Each option can be used exclusively, or more than one can be used as a mechanism to generate revenue for an exchange's operations.

II. Exchange Fee Charged to Plans

A fee may be charged to insurance carriers offering coverage through the exchange. Although insurers and policy makers may normally be adverse to taxes, licensing or regulatory fees, the Patient Protection and Affordable Care Act (ACA) requires that federal and state taxes and licensing or regulatory fees be excluded from the total amount of premium revenue when calculating an issuer's medical loss ratio (MLR).³ Therefore if these fees can be characterized as a federal or state tax, a licensing fee or a regulatory fee, then it will benefit the insurers for purposes of the rebate calculation for an issuer's MLR calculation.

Exchange fees should be fair and used solely for the purposes of operating the exchange. However, exchange fees applicability could be either broad or narrow with regard to exchange participants and with regard to stakeholders that benefit from the exchange. For example, Massachusetts charges an assessment fee for all exchange participants (states could also consider a fee on all insurers selling in their state inside or outside the exchange), whereas Connecticut charges dues to anyone participating in their exchange (consumers, employer and insurers). Some carriers have expressed that the per member per month assessment on carriers should be kept to a fair limit and provided the example of no more than \$2 per member per month.

III. Service Fee to Consumers

A fee may be assessed on consumers who purchase insurance through the exchange. The benefit of the fee on users is that it is transparent and obvious to the user. The fee either alone or in combination with other financial mechanisms must cover the administrative costs of the exchange, which is expected to service a large number of users who will not be purchasing insurance. The fee would therefore only be assessed on a portion of the actual exchange users. This fee must be large enough to cover such costs, but not so large as to dissuade a purchaser from buying insurance on the exchange. The other option is to assess the fee on each insurance policy purchased in the state whether on or off the exchange. This could balance the playing field for products on the exchange, but has the impact of increasing costs on individuals who are not accessing benefits. For example, Utah assesses a \$2 and \$4 per employee per month charge for exchange utilization by consumers to pay for the two exchange vendors. Another option would be to charge a small fee for access to the Exchange, similar to a membership regardless of whether items are purchased. This may provide a broader base in which to assess charges reducing the fee charged to each individual, but has potential to discourage users. The charges are clearly listed and cover each of the vendor costs. It is likely that any user fee would need to be in combination with other financial mechanisms in order to generate enough revenue.

¹ 42 USC § 18031(a)(2).

² 42 USC § 18031(c)(5)(A).

³ 42 USC § 300gg-18(a)(3).

IV. Other Revenue Generating Fees

Any number of fees could be assessed upon carriers, individual consumers, employers, agents and/or navigators. For example, some states may choose to require navigators to be licensed agents or receive some sort of special licensing or training. To the extent such state wishes to do so, an annual fee could be assessed for such licensing, training and/or certification. It is unlikely that a state could raise all funds necessary from such a fee, so it is likely that this would also need to be in combination with other fees. Because products sold through exchanges must be certified,⁴ a fee could be assessed on those companies seeking certification to cover such costs. In addition, states could consider imposing an assessment on providers, hospitals and clinics (presuming the argument can be made and substantiated that these stakeholders benefit by the expanded access to funding for services). Finally, a fee could be structured either as a percent of premium or on a per enrollee charge.

V. Advertising

Advertising on the exchanges' websites is a creative way to generate revenue and to incentivize people to return to the exchange at other times during the year besides when enrolling for health insurance. If the exchange can be viewed as a one-stop-shop for all health care needs, it not only enhances the traffic flow throughout the year and gives the exchange an opportunity to leverage more revenue, but it also reduces the stigma sometimes associated with public entities and/or programs.

Advertisers could be limited by category, but they should be diverse enough to target multiple demographics (especially those that are least likely to seek a major medical health policy, i.e., younger, healthy members of society). Like Expedia's or Priceline's business model that offers complementary advertisements to travel, a health exchange could adopt a similar financing model that complements health care and/or wellness as well. The exchange could receive a cut of these complementary sales and successes could result in long-term partnerships. For example, the following types of advertisers might be representative of complementary advertisers for a state's exchange website:

- Hospitals, insurers, providers; producers;
- Health and fitness clubs; local municipal parks and community health programs;
- Health/Food Products;
- Education;
- Fitness Merchandise and wear;
- 5K Races, Mini-Marathons and walk-a-thons;
- Weight loss programs (i.e., Weight watchers, Jenny Craig)
- Smoking cessation services and Devices (products); and
- Health finance products.

Additionally, advertisers could target consumers and tailor their ads based on demographic information consumers entered or the internet protocol (IP) address.

Other types of advertising revenue could be generated similar to how Facebook generates its revenue based on a pay-per-click model. For example, if Company X Health advertises on the exchange it would only pay when a consumer clicks on its advertisement but rather than for the privilege to display the advertisement. Company X Health could set a daily budget with a not to exceed amount based on an amount per click for its advertisement. Thus, suppose Company X Health wanted to budget \$5.00/day to advertise on the exchange. It could receive 50 clicks at .10 cents per click and meet its daily budget of \$5.00.

Administrative costs may slightly increase by the need to establish advertising standards and approve such advertisements, but such costs could be easily offset. The potential benefit of funding an exchange without assessments to consumers, insurers, producers and/or providers or with minimal assessments is attractive, particularly in times of such financial hardship. States that choose to run the exchange through a state entity may be less attracted or restricted from doing this due to state laws or public perception. States establishing a not-for-profit model to run the exchange may have more freedom to consider this option.

⁴ 42 USC § 18022(d)(1)(A), (B), (C), (D).

VI. State Funding Via Appropriations to the Exchange

California's exchange is currently funded through its general revenue fund. One view is that it spreads the cost over all insured individuals (including self-funded). Similarly, a state may consider using existing tobacco tax dollars or possibly create a new excise tax to cover exchange costs. States should also consider existing premium taxes and how they are used. If that funding is used for high risk pools or other health related programs that may not be needed in the future, those funds may be re-directed to fund the Exchange.

Many states also have a premium tax, which is assessed on policies sold within a state. It has been stated that the mandate to have insurance will increase the amount of insurance sold in a state. Since more policies will be sold, states with this tax may leverage the additional revenues from these premium tax revenues as a mechanism to finance their exchanges. However, gross premium tax revenues may actually decline in states even with the increased amount of policies sold within a state because of the cost-sharing reductions and the refundable tax credits that are available via ACA for individuals whose incomes are between 133%-400% of the federal poverty level (FPL).⁵ However, diminished premium tax collection may be offset through sale or other taxes assessed because of increased disposable income to those who qualify for the tax credits being able to divert money from health insurance expenditures to other priorities.

For example, insurance premium taxes are usually solely within the jurisdiction of a state's taxation authority, and a state's tax court(s) determines gross receipts for purposes of levying the premium tax on policies. In regards to subsidies, some state tax courts may determine tax consequences based on the substance of the transaction, not its form. In this instance, a court would determine that since the subsidy is used to offset the cost it is not going to the substance of the transaction but to its form and the subsidy portion used to offset the cost is not part of the premium gross receipts. This could affect existing premium tax revenues in states, and the additional premium tax revenues that would have been generated because ACA expanded access to health care financial products.

In many states, ACA subsidies that will apply to those individuals whose incomes are 133%-400% of FPL will encompass a large portion of a state's population, and those eligible for the subsidies will now presumably have more discretionary income to spend. Because of this shift in revenue streams, states have opportunities to capture more sales taxes and other revenues since more individuals will have more discretionary money. In sum, actuarial and budgetary projections can be used to determine these amounts to potentially justify the appropriate amounts that can be allocated to the exchange from a state's general fund.

VII. Conclusion

The financing mechanisms mentioned above are not an endorsement of one or the other nor does this paper contemplate the plausibility of implementing one versus the other in any of the states. The complexity of health care reform and the financial challenges of implementing it make it necessary to present a variety of financing options so that individual states can weigh the pros and cons of each before settling on a comprehensive financial model that fits each state's needs and values.

⁵ 42 USC § 18071(b)(1)-(2); 26 USC § 36B(b)(2)(A).