

Health Insurance Exchange

Draft

Policy Recommendations

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I. BACKGROUND

1. What is an Exchange?

A health insurance exchange is a central marketplace for health insurance that provides one-stop shopping for individuals and small businesses to compare rates, benefits and quality among plans. The exchange will also administer the new federal health insurance tax credits for those who qualify and make it easier to enroll in health insurance.

Beginning in 2014, an exchange will be available in each state to help consumers make comparisons between plans that meet quality and affordability standards.

2. Recent Reform Proposals Included Exchange

Oregon Health Policy Commission: *Road Map* Recommendations

In 2006, the Oregon Health Policy Commission (OHPC) developed recommendations for establishing a system of affordable health care that would be accessible to all Oregonians. In the resulting report, *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*, the OHPC recommended that the state create a health insurance exchange in order to make affordable coverage options and public subsidies available to individuals and employers. The OHPC recommended that the exchange be governed by an independent board and use all the tools available to purchasers to support value-based purchasing and encourage individuals to manage their medical care and health.

The OHPC's vision included an exchange that offered insurance plans for sale, acted as a smart buyer that worked to drive market change and delivery system reform through plan design, member education and incentives, quality reporting and incentives, cost controls and other value-based purchasing techniques. The exchange would reduce employer administrative burden and offer increased employee plan options in order to attract small employer participation. The OHPC recommended that the exchange be used on a voluntary basis, driving quality by negotiating and collaborating with insurance carriers and producers.

Oregon Health Fund Board: *Aim High* Recommendations

Following on the recommendations laid out in the OHPC report, the 2007 Oregon Legislature passed Senate Bill 329, establishing the Oregon Health Fund Board (OHFB). The OHFB was tasked with developing a comprehensive plan for health reform in Oregon.

Access to affordable, quality health care for all Oregonians was a key Board objective. To achieve this, the Board proposed a five-part effort to expand access to affordable health care for all Oregonians. An exchange was proposed as the mechanism for expansion of individual insurance coverage in the state. Like the OHPC, the OHFB recommended a health insurance exchange that would help standardize and streamline administration, promote transparency for consumers, improve quality, stem cost increases for individual insurance purchasers, and coordinate premium assistance for low and middle income Oregonians. As the OHFB report was written prior to federal reform, the Board saw the exchange as an entity that could grow over time and be used to facilitate market changes. Participating insurance carriers would be required

to meet standards in: plan options offered; network requirements; adherence to standardized contract requirements based on evidence-based standards; transparency; common tools; and additional administrative cost and rating rule standards that could be developed by the exchange.

The OHFB's Exchange and Market Reform Work Group made additional recommendations regarding an exchange. While the group did not reach consensus on a number of issues, the majority of the group recommended that the exchange operate as a strong market organizer by contracting with carriers and establishing performance benchmarks across carriers. The group supported an administrative structure that facilitates accountability, transparency and responsiveness, and allows flexibility and market responsiveness.

House Bill 2009: Develop an Exchange Business Plan

The Oregon Health Fund Board's comprehensive plan for health reform led the 2009 Legislature to pass House Bill 2009. Among much other health reform work laid out in the legislation, HB 2009 directed the newly created Oregon Health Authority to develop a plan for an exchange in conjunction with the Department of Consumer and Business Services (DCBS).

3. Federal reform

Federal Reform and Market Changes

In March 2010, the Patient Protection and Affordable Care Act of 2010 (PPACA) was adopted by Congress and signed by the President. The law¹ makes a number of changes to the insurance market in the United States. Starting in 2014, individual and small group insurance will be offered on a guaranteed issue basis, meaning that individuals can not be refused insurance for past or current health care use or needs.² In addition, the law requires most U.S. citizens and legal residents to get insurance coverage or face an annual financial penalty.

The federal law creates five benefit levels: bronze; silver; gold; platinum; and a plan with more limited coverage that will be available only to young adults and people exempt from the mandate to get health insurance. While the benefits in these plans are likely to be fairly similar, they differ in terms of the level of cost-sharing allowed under each. Starting in 2014, no health insurance policies can be issued that do not meet the actuarial standards set for these plans.³

Exchange Participation. Individual market purchasers and small employer groups may use the exchange to buy insurance.⁴ Use of the exchange is voluntary, although premium tax credits will be available only for plans purchased through the exchange. Starting in 2014, small employer tax credits will be tied to purchasing group insurance through the exchange.

¹ The Patient Protection and Affordable Care Act is now Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

² House Bill 2009, Section 17 (1)(a)(B) The rating and underwriting standards applicable to the exchange, including whether to incorporate community rating and guaranteed issue; (1)(a)(E) Enforcement of the rules governing the sale of insurance within the exchange.

³ The one exception is for so-called "grandfathered plans," coverage issued before March 23, 2010.

⁴ As discussed in Recommendation 14, staff suggest that the exchange serve individuals and small groups with up to 50 employees in 2014-15, opening to groups of 51-100 in 2016 as required by federal law.

Individuals with household income under 133% of the federal poverty level (\$29,326 for a family of four in 2010) will be able to get coverage through their state's Medicaid program. Children with income up to 200% FPL will continue to access the Oregon Health Plan (Oregon's Medicaid program). Medicaid eligible individuals who come to the exchange will be provided assistance with enrollment in OHP. The "no wrong door" philosophy will ensure that everyone receives help enrolling in the appropriate program and receiving premium assistance where eligible, without regard to where they go to access that assistance.

Premium and Cost Sharing Assistance. To maximize the number of people with access to affordable coverage, the law establishes premium tax credits for individual market purchasers with income between 133% and 400% of the federal poverty level (\$29,326-\$88,200 for a family of four in 2010). The tax credits are advanceable, meaning that they can be used to offset monthly premium costs rather than having a purchaser pay for insurance and get reimbursed annually.

The premium credits will be based on the second lowest cost silver plan in a geographic area. Credits will be on a sliding scale with participant premium contributions limited to the following percentages of income for given income levels:

- Up to 133% of the federal poverty level (FPL): 2% of income
- 133-150% FPL: 3 – 4% of income
- 150-200% FPL: 4 – 6.3% of income
- 200-250% FPL: 6.3 – 8.05% of income
- 250-300% FPL: 8.05 – 9.5% of income
- 300-400% FPL: 9.5% of income

In addition to making coverage more affordable for many people, the federal law establishes an affordability standard. The law provides cost-sharing subsidies for eligible individuals and families with income up to 250% of the federal poverty level. These credits reduce health insurance cost-sharing amounts and annual cost-sharing limits. These credits increase the actuarial value of the basic benefit plan, with the value of the additional coverage increasing as the participant's income decreases.

Workers whose employers offer coverage can not access premium tax credits for individual market coverage in the exchange. However, if employer-sponsored insurance will cost an employee between 8-9.5% of income, the employer must give the employee a "free choice voucher" equal to the amount the employer would have paid for the employee's coverage in the group product. The worker can then take the voucher and use it to purchase coverage in the exchange. In a situation in which employer coverage would cost the employee more than 9.5% of income, the employee can go to the exchange and purchase individual market coverage using federal premium tax credits.

What Federal Law Requires of Exchanges

Section 1311 of the Patient Protection and Affordable Care Act requires states to establish exchanges for individual and small employer group purchasers. The federal law establishes some parameters and lays out areas in which the Health and Human Services Secretary will provide guidance and regulations for states' use.

The federal law guides the state's development of an exchange in a number of areas:

- Basic exchange functions (e.g., plan certification, customer service, information provision, exemption administration)
- Open enrollment periods
- Minimum benefits standards for exchange products (to be defined in regulation)
- Requirement that the state exchange be self-sustaining by January 2015.
- Requirement that the exchange consult with stakeholders.

Where the federal requirements specify state exchange functions or structures, this is noted in the recommendations presented in this report.

Timing of Exchange Development and Market Reform Implementation

The Oregon Health Authority is applying to the federal Department of Health and Human Services, Office of Consumer Information and Insurance Oversight (OCIIO) for an exchange planning grant. States' applications are due by September 1. The grants of up to \$1 million per state will be announced at the end of September. During the one year grant period, states will develop their exchange plans. Some States will use the planning period to decide if they will build an exchange, while others will make key decisions such as whether they will have one exchange or two or will build regional multi-state exchanges. Oregon is planning to use the grant funding to develop a detailed operational plan based on the business plan to be submitted to the Legislature in December, 2010. This draft report is the first step toward building a plan that will be submitted to OCIIO in preparation for the implementation of an exchange in Oregon.

The federal government will approve state exchange plans before January 1, 2013. This will allow states to implement their exchanges in time to conduct a public education campaign and an open enrollment period in the summer or fall of 2013. Coverage under plans sold through the exchange will begin January 1, 2014.

Also on January 1, 2014, all health insurance coverage offered in the United States will be guaranteed issue, meaning that an insurer must accept anyone regardless of pre-existing conditions, gender or age. This will apply to all plans sold through an exchange and in the outside market. The national requirement to obtain health insurance coverage also goes into effect on this date.

4. Oregon Health Policy Board and Exchange Development

Oregon Health Policy Board Identifies Exchange Goals

In February 2010, the Oregon Health Policy Board expressed the following goals for a state exchange:

- A. Increase access to health insurance coverage;
- B. Change the way we pay for care;
- C. Simplify plan enrollment, health plan rules, state health insurance regulation, and plan designs; and
- D. To the extent possible, contain health care costs.

In a subsequent meeting in May the Board further expressed the hope that an exchange could make strides to ensure affordability for members and address health equities. Operational sustainability of the exchange will be a focus, putting a focus on adequate enrollment, ease of access, and good customer service. For more on this please see the Policy Recommendations section for a discussion of the vision for a successful exchange.

Technical Advisory Group

In May and June 2010, a technical advisory work group was convened to provide input to staff on a number of strategic issues. The group included representatives from a variety of perspectives, including consumer advocacy, organized labor, insurance agent, insurance carrier and provider. In its discussion of an exchange, the work group indicated that it valued the following qualities in an exchange: efficiency; flexibility; accountability; and a consumer focus.

The group met three times to talk about a variety of issues on which the state has design flexibility. Feedback from the group's discussions helped staff identify the possible options for the various issues discussed in this report, as well as the implications of various choices.

Staff Recommendations to the Board

The recommendations that follow are the work of Office for Oregon Health Policy and Research and Oregon Health Authority staff. The technical advisory group provided information and opinions. Recommendations were developed by staff through research, analysis and discussion during the spring and summer of 2010. Staff attempted to provide both recommendations and analysis in this report, offering a flavor of the analysis they went through to come to their recommendations as well as the implications of various choices.

II. POLICY RECOMMENDATIONS

Envisioning a Successful Exchange

A successful exchange will provide useful and timely assistance to Oregonians, improving their access to insurance coverage and health care. The exchange will be available through multiple media, including a web site, telephone, printed materials and in-person assistance. The health plan choices available through the exchange will meet the diverse needs of consumers across the state, providing meaningful choice without confusing consumers with “differences without distinction.” It will make enrollment easy and provide ongoing service, improving access to insurance coverage and health care.

A successful exchange will develop and grow based on consumer’s needs over time. It will have robust enrollment, provide a range of health plan choices, score highly in measures of customer service, and be financially sustainable in terms of its administrative costs and participant risk pool. The exchange will be nimble, flexible and responsive, allowing it to be consumer and service oriented. It will use the best available technology support systems, and will grow by earning the trust of its users based on service and value. This will allow the exchange to be financially strong and sustainable over the long term.

Based on the Goals identified by the Board and the associated vision of a successful exchange, staff recommends the adoption of the following recommendations:

A. ELEMENTS OF AN EXCHANGE – Governance

Governance is the process used and the rules followed to make decisions about how an organization operates. This section addresses proposed structural oversight for the exchange.

Recommendation 1: A Strong Consumer-Oriented Mission will Guide the Exchange

To ensure that Oregon’s health insurance exchange is focused on improving service and access for consumers:

- The health insurance exchange must have a strong consumer-oriented mission that guides the work of the exchange board and executive leadership team.
- The mission must clearly articulate that the exchange is run for the benefit of Oregonians.

Discussion

The goals outlined by the Health Policy Board focus on ways of improving access and service for consumers. Facilitating access, simplifying options, enrollment and regulation, changing how services are provided, and containing costs are all intended to improve the experience of getting and keeping insurance coverage for Oregonians. To ensure that these goals shape the development, implementation and long-term functioning of the exchange, it will be important to have a clearly articulated, strongly held mission that guides the work of the exchange board and executive team. This mission would also signal to consumers and business that the exchange is working in their best interest and exists to improve access and services for them.

Recommendation 2: The Exchange Should be Guided by a Governing Board and Led by a Strong Executive Team

To ensure that the exchange is well-governed, sustainable and responsive to individual and group consumers, payers, the state and other stakeholders the exchange should be overseen by a governing board that:

- Meets at least monthly to focus on the implementation, administration and sustainability of Oregon's health insurance exchange.
- Is broadly representative and include as members individuals chosen for their professional and community leadership and experience.
- Includes as members the directors of the Oregon Health Authority and the Department of Consumer and Business Services.
- Provides policy guidance to exchange leadership.
- Establishes consumer advisory boards to advise the exchange board.
- Provides direction to the exchange executive leadership team as it implements and administers the exchange based on board leadership, the organization's mission and the requirements of federal law.

Discussion

Governing Board. A number of organizations in the state utilize governing boards, including public corporations such as the port authorities and SAIF Corporation. The Massachusetts Connector Authority, which governs that state's exchange programs, utilizes a working board as well.

Board Role. The exchange board should meet at least monthly or more as needed. Initially the board is likely to need to meet at least twice a month for some period as the executive team is brought on and the exchange is planned and implemented. The board will focus on implementation, policy and sustainability issues. It will work closely with the exchange executive leadership.

Membership. Board members should be chosen for their professional and community leadership and experience, rather than represent identified constituencies. The board should include persons with strong background in business, consumer advocacy, health care and community service.

An exception to a "skills and experience, not role" orientation is that the Director of the Oregon Health Authority and the Director of the Department of Business and Consumer Services should be exchange board members. These members will be *ex officio*, which is to say, board members based on their positions as directors of their respective departments. The model for including *ex officio* members is the Massachusetts Connector Authority's board, which includes four *ex officio* members: the state's Secretary of the Executive Office for Administration and Finance; Medicaid Director; Secretary of the Group Insurance Commission; and Commissioner of the Division of Insurance. In addition, a member of the Oregon Health Policy Board should be included on the exchange board in order to ensure coordination between the two groups.

The Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) requires state exchanges to consult with stakeholders, including qualified health plan enrollees, individuals or

organizations that help people enroll in plans, small business and self-employed representatives, state Medicaid, and advocates for enrolling hard-to-reach populations. The exchange board can fulfill this requirement to some extent and it can also facilitate additional consultation through a board appointed advisory committee of stakeholders that would report to the board on a regular basis.

Members should be appointed by the governor and confirmed by the state Senate. Terms should be staggered and after the first group of appointees, last for four years with the potential for one reappointment for an additional four years. The governor can appoint a replacement immediately upon a vacancy.

Consumer Advisory Boards. In addition to a governing board, the exchange should establish stakeholder advisory boards, including one for consumers purchasing individual insurance through the exchange, one for small businesses using the exchange and the brokers who assist them, and one for participating carriers. Establishing such groups by statute will encourage and facilitate input by a variety of stakeholders on issues related to the functioning of the exchange, the services it provides and related issues, while allowing the exchange governing board to remain a small group of between five and nine members. These groups would be established to provide input and advice to the board and executive leadership of the exchange.

Executive Leadership Team. While the exchange board will provide guidance based on the organization's mission, the executive leadership is the group that will act on the mission and board guidance, ensuring that the exchange operates as a consumer-oriented organization that improves access, quality customer service and, in partnership with participating health plans, improves the patient's experience of care and contains costs for health care and insurance. The executive leadership team will draw on their experience with financial management, information technology, the insurance industry, marketing and communications (including a focus on customer care), organizational management and operations.

B. ELEMENTS OF AN EXCHANGE – Organizational Structure

Organizational Structure addresses how divisions, programs, positions are placed in an organization and how levels of authority are defined. This section provides recommendations regarding the structure of an exchange in Oregon, including the type of organization, populations served, geographic scope and how to address what functions are kept in house and which are contracted out.

Recommendation 3: Establish the Health Insurance Exchange as a Public Corporation

Oregon's health insurance exchange should be a public corporation chartered by state statute.⁵ A public corporation can be accountable to the public interest but not beholden to state politics or budget cycles. No matter what model is chosen for the exchange, the entity must be given authority and flexibility under statute to do its work.

⁵ There is no specific public corporation statute in Oregon. An exchange can be built with specific roles, authority and responsibilities in state statute. The State Attorney General's office will be consulted in the development of such statutory language.

Discussion

Staff, with assistance from the Exchange Technical Advisory Work Group, identified the following characteristics as desirable for an exchange organization:

- *Flexibility and agility*: as federal reform rolls out, best practices change over time and other state and federal changes occur, flexibility is a necessary component.
- *Responsiveness*: to consumers, health plans and the state.
- *Consumer Focus*: provide value and improved access for individual and group purchasers.
- *Ability to work with existing state agencies*: including the Insurance Division and Oregon Health Authority.

In considering whether an exchange would best be created as a public agency, a private non-profit or a public corporation model, staff discussed each option in light of these characteristics.

Flexibility/Agility. To facilitate the exchange's ability to focus on consumers and to maintain good relations with the insurance carriers that will serve the consumers, the exchange must be able to act quickly on its consumers' behalf. Due to state procurement, hiring and human resources rules, state agencies are generally not very nimble or flexible. Exemptions can be made from specific rules, but authority to waive specific rules must be given in statute to ensure a state agency exchange has the flexibility it needs to be flexible and responsive. A public corporation can be independent from state fiscal processes and insulated from political wrangling, offering flexibility in the face of change. This model has worked well in other sectors, including the state's Port Authorities. Like a public corporation, a private nonprofit model is inherently more flexible and agile than a state agency.

Responsiveness. Oversight is easily achieved for a state agency. Its ability to be responsive to stakeholders outside of the state government would vary, potentially hampered somewhat by the limited flexibility of state rules. Consumer advocates have argued that a state agency would ensure accountability to consumers. A government agency would exist for the benefit of consumers. A public corporation or non-profit can build in accountability and responsiveness to the public by clearly identifying these as core missions of the organization, while simultaneously prioritizing flexibility and agility as well. To ensure this, authorizing legislation may need to specify that the entity will have a consumer-focused mission.

Another way to build in oversight and accountability is to require state officials to participate as ex officio members of the exchange's governing board. While agency representatives are non-voting board members in Massachusetts, to strengthen the link between state agencies and the Oregon exchange, ex officio members could be included as full voting members of the exchange board.

Consumer Focus. For an exchange to be a successful business, it must enroll and retain customers. This is a business task as much as anything else. A state agency can provide good customer service if provided with strong leadership. An exchange is federally required to conduct a range of consumer oriented tasks. Concerns exist about the ability of a state-agency exchange to conduct its federally mandated business in tight fiscal times such as the one currently facing Oregon.

Ability to work within state structures. A state agency would fit within the Oregon Health Authority's model of state health care programs consolidated in one agency. A non-profit or public corporation could coordinate with state agencies. Statutory direction to all agencies to coordinate would be necessary no matter what structure the exchange takes.

The exchange can not be hobbled by the budget cuts or political wind changes that can greatly affect state agencies. A public corporation funded by user fees would exist outside of the state budgeting and legislative cycles that define many state agencies.

Public perception. The public corporation and non-profit models avoids the "welfare" stigma that can hamper a state agency; the perception that a state agency running a government program must be a social service program aimed at the low income population. While many people understand that the subsidy portion of the exchange is available for both moderate and middle-income Oregonians, distaste for public programs could might turn off some potential enrollees.

While some Oregonians may be scared off by a state agency-administered exchange, many people will trust the public models (a state agency or public corporation), knowing that public-sector entities have a public-focused mission. Non-profits can certain have a public mission, but it is not implied that this organization-type will have this orientation.

Mission, oversight and leadership are key. In discussion with the technical advisory work group, it became clear that it is less important which type of organization is chosen than it is that the exchange has a clear mission that is carried out by a strong governance board and executive leadership team.

Recommendation 4: Establish the Exchange as One Organization with Individual and Small Group Product Lines

- An exchange should operate as a single organization that offers products and services targeted at individual and small employer group customers.
- Using a common entry point, access to the correct information and assistance will be provided based on information provided about the consumer's needs and interests.

Discussion

The federal Patient Protection and Affordable Care Act requires states to build an exchange for individual market purchasers and a Small Business Health Options Program (SHOP) exchange. The law allows a state to combine the individual and small group exchanges into one organization as long as the state has the resources available to do so.

Single entry-point. From a customer service perspective, having "one door" for all purchasers means that people are not turned away from or frustrated by an attempt to get information or to enroll in insurance through the "wrong" entry point. Technology exists to allow customers to provide some basic information and be seamlessly offered relevant options.

Efficiency. Developing a single exchange for both populations is more efficient than building two parallel organizations, each with its own administrative and technological needs. If two organizations are built, they could utilize a shared services model, but this does not appear to be as efficient as building an exchange as a single entity with two product lines.

Build seamless entry. The development of the technology needed to ensure simplified and seamless use of a single entity with multiple product lines will require significant financial and other resources. While the development will take some effort, the resulting infrastructure can improve access for both individual and small group insurance purchasers.

Promoting Smooth Transitions. Individuals may need to move between group and individual coverage due to job or other changes. The exchange will provide increased value for consumers to the extent that it can minimize disruption of health care due to such changes. A single exchange can actively encourage participating carriers to offer both individual and group market plans. While a carrier's bronze plan for groups may not be identical to its individual bronze product, the network generally remains the same across plans. Ongoing access to providers is one of the key ways disruption is minimized for people switching between a carrier's group and individual coverage. Carriers will have an incentive to participate in both markets in order to retain individual purchasers who leave group coverage. The exchange should facilitate smooth transitions between coverage as people move between jobs or make other changes that affect insurance coverage.

Recommendation 5: Utilize One Exchange that Services the Entire State

Build a single statewide health insurance exchange to provide targeted information and enrollment assistance and other help to consumers based on basic consumer information such as area of residence.

Discussion

The PPACA allows states to operate one or more subsidiary exchanges in distinct geographic regions of the state. While Oregon includes urban, rural and frontier areas that face different market conditions, for the most part Oregon is a single market. This is in contrast to some larger states such as California or New York that have very distinct geographic and demographic regions within a single state. Such larger states could benefit from regional exchanges, but in Oregon the market is really a statewide one with regional variation. A statewide exchange can harness one pool of funds to provide web and phone access available statewide.

Recommendation 6: Oregon Should Pursue its Own Exchange But Consider Partnership with One or More States

Pursing a single state exchange in Oregon will allow the state to pursue its own policy decisions. While partnering with another state to build a regional exchange could provide some benefits in terms of administrative cost savings, such savings are limited in terms of total dollars, and the challenges of working with two sets of state rules, legislatures, and administrations would be significant barriers to the efficient and timely development of an exchange. It is worth

investigating whether Oregon can partner with another state in order to save money on contracting for specific services.

Discussion

A successful exchange will rely on enrolling a meaningful consumer base within a relatively short time period. If two or more states joined together to build an exchange, this could help guarantee a larger number of participants, which could spread administrative costs over more people. Further, as all states will be setting up similar entities, economies of scale could be expected if two states share exchange administration. For Oregon, the most obvious partner is Washington, as the two states share some common insurance carriers and health plans, and a sizeable number of people live in one state while working in the other.

These considerations may make the development of a multi-state exchange look promising. However, such an endeavor has costs. While sharing infrastructure development and maintenance can reduce costs, administrative costs for the exchange are a small portion of the total costs of purchasing insurance. A one percent reduction in administrative costs would be a fraction of a percent reduction in the total cost of insurance purchase for exchange participants. Such a reduction is not worthless, but should be considered in terms of the additional effort needed to develop and implement a cross-state exchange.

In addition, exchange development will require legislative action. Building a multi-state exchange would necessitate getting the approval of two state legislatures and two administrations. Every design issue, from the structure and oversight of the exchange through the smallest administrative rules and HR policies would have to be agreed to by officials in both states. Adding to the challenge are states' differing legislative timelines and individual economic circumstances facing each state. As the potential savings are not large, the likely hurdles involved in establishing and maintaining a multi-state exchange appear even more daunting. Pursuing a single state exchange in Oregon will allow the state to pursue its own policy decisions without compromising those goals and plans in order to reach agreement with another state.

A further consideration is that a successful exchange is one that is able to provide relevant assistance to individuals in a local area. A multi-state partnership does not improve the exchange's ability to provide good, locally useful information and support to its customers.

To benefit from the efficiencies of working with another state while avoiding the complications of a full interstate exchange, the state should investigate ways it can partner with neighboring states on infrastructure development and other operational tasks without entirely yoking its policy development and operations planning to that of another state.

C. ELEMENTS OF AN EXCHANGE – Operations

This section identifies the federal Patient Protection and Affordable Care Act's requirements for state exchanges and lays out staff recommendations for the areas that the federal law allows state flexibility.

Federal Guidance and Requirements

Exchange Functions as Defined in the Federal Patient Protection and Affordable Care Act

Each state exchange must provide the following services:

1. **Certify plans** for participation in the exchange, including implementing procedures for plan certification, recertification and de-certification based on federal guidelines.
2. **Make qualified health plans available** to eligible individuals and employers.
3. **Provide customer assistance** via telephone and website. Have a toll-free telephone hotline to respond to requests for assistance and maintain a website through which enrollees, prospective enrollees can get standardized comparative plan information.
4. **Grade health plans** in accordance with criteria to be developed by the federal Department of Health and Human Services. This includes using a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage, and maintaining a website through which enrollees and prospective enrollees of qualified health plans may get standardized comparative plan information.
5. **Provide information to individuals and employers**, including providing information regarding eligibility requirements for Medicaid, CHIP and any applicable State/local public program. The exchange will provide an electronic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction. The exchange will publish: the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse. In addition, the exchange will provide employers with the names of any of their employees who stop coverage under a qualified health plan during a plan year.
6. **Administer exemptions** to the individual responsibility penalty when: no affordable qualified health plan is available through the exchange; or the individual meets the requirements for another exemption from the requirement or penalty.
7. **Provide information to federal government** regarding: Oregonians issued an exemption certificate; employees determined to be eligible for premium tax credits; and people who tell the exchange they changed employers and stopped coverage during a plan year.
8. **Facilitate community based assistance** by establishing a Navigator program.
9. **Have an annual open enrollment period**, special enrollment periods, and monthly enrollment periods for Native Americans.

DHHS to Offer Additional Guidance

The federal Department of Health and Human Services will offer guidance and promulgate regulations in a number of areas, including requirements for: the certification of qualified health

plans; a rating system that states will use to rate plans offered through the exchange on the basis of relative quality and price, for use by individuals and employers; and an enrollee satisfaction survey. In addition, the HHS Secretary will be providing regulatory guidance on the details of the benefits package that will be considered acceptable minimum coverage to meet the individual insurance mandate.

Recommendation 7: Individual and Small Group Purchasers will be able to Buy Insurance Inside or Outside of the Exchange

Consistent with the requirements of federal law:

- Oregon's exchange should be available for individuals and small group purchasers.
- Use of the exchange is voluntary.
- Individuals accessing federal tax credits for insurance purchase will be required to use the exchange to buy insurance.

Discussion

The federal health reform bill does not direct states to make the exchange the sole market for individual and small group purchasers, but it leaves open the possibility for individual states to make rules about the exchange's role in their state insurance markets.⁶

The Exchange Work Group of the Oregon Health Fund Board recommended that the exchange be the venue for people to access premium subsidies, but that people buying insurance without public subsidies access the exchange on a voluntary basis.

Single Market Implications. An exchange that is the sole market would be larger than one that would exist in the context of a dual marketplace. An exchange as the sole market could more easily be a force for change in a marketplace in which it sets the rules for all insurance purchasers. In a split market, the exchange can still work to improve quality and reduce costs for consumers, but its ability to do this will depend in large part on the size it achieves. A larger population within the exchange will make it more likely for changes implemented within the exchange to be implemented in the outside market as well. In a dual market, the exchange must work to prove its value to consumers. Where choice is available, the exchange must make itself the preferred option by providing the best possible products, customer service, information and support.

Limiting Choice, Limiting Risk Selection. If the exchange is the only market, this could limit choice for insurance purchasers. An insurance carrier that did not meet the exchange's standards for participation would effectively be kept out of the state's entire health insurance market.

A single market would eliminate the potential for risk selection between an exchange and outside market. With two markets, one more insurance carriers could receive unequal risk either inside

⁶ In addition, House Bill 2009 allows the exchange business plan to address the issue whether the exchange should be the exclusive market for individual and small group purchasers, or whether consumers would continue to have the option of buying insurance inside and outside the exchange. *HB 2009, section 17(b)(C)*

or outside the exchange. This could happen randomly or due to the behaviors of one or more carriers in the market. However, in a dual market in which all of a carrier's members form a single pool and premiums for a given product are the same inside and outside, risk selection is greatly mitigated. The federal law requires the pooling of risk across the entire market and mandates that prices for a plan are the same inside and outside of the exchange. Risk for grandfathered plans (those issued before March 23, 2010) is separate, though the exchange and free choice vouchers will likely have some impact on them.

Input from the Technical Advisory Work Group. Members of the technical advisory work group indicated that they preferred a dual market system. Some members wanted to limit disruption for individuals and business that are happy with their current coverage. Others were concerned that an exchange that is the only entry point to the market may face challenges in trying to increase quality, cost and efficiency standards. The concern centered on a public corporation playing a regulatory role for the whole state. This was not considered a problem if the exchange is established as a state agency.

Recommendation 8: Utilize Benefits and Other Requirements to Ensure Carrier and Plan Participation Provides Meaningful Consumer Choice

- Establish benefits and other requirements for health plans participating in the exchange.
- Do not arbitrarily limit carrier participation in the exchange to a specific number of carriers or products.
- Ensure meaningful plan choice by helping purchasers navigate options based on individual preferences and needs.
- Retain the authority to increase or change participation standards based on the experience of the exchange over time.
- Establish a "high value" designation to identify health plans that meet higher quality and/or cost standards.

Discussion

The federal health reform law allows states to set insurer participation rules within the framework of the federal law and regulations on the subject. States may limit participation to carriers that meet exchange standards and for which their participation is considered to be in the state's best interest.⁷ In addition, House Bill 2009 allows the Health Policy Board to establish criteria for the selection of insurance carriers to participate in the exchange and requires the Board to consider ways to maximize the participation of private insurance plans in the exchange.⁸

In its discussion of plan participation in the exchange, the exchange technical advisory work group considered the extent to which plan choice is beneficial to consumers. The group

⁷ *PPACA Part II, Section 1311(e)*

⁸ House Bill 2009, section 17(b)(A): "Establishing criteria for the selection of insurance carriers to participate in the exchange." Section 17(a)(H) "Maximizing the participation of private insurance plans offered through the exchange."

discussed how much choice is valuable and at what point too many choices becomes a barrier to informed decision-making. The group was in general agreement that while choice is beneficial, it should be meaningful choice for the consumer, rather than a way for carriers to segment the market in a way that does not help consumers.

Set Standards and Allow Entry by Qualifying Plans. All carriers wanting to sell products in Oregon's individual and small group markets will continue to have their plan rates approved by the Insurance Division, whether the carriers sells plans inside or outside the exchange, or both.

Federal law allows the exchange to establish health plan certification standards for carriers seeking to participate in the exchange. The exchange should have statutory authority to establish additional plan participation standards. Using this authority, the exchange can define standards that are strong enough to ensure quality while not so stringent as to unnecessarily limit choice of plans. Meeting the exchange's requirements is then up to the carriers.

Health plans sold through the exchange will meet additional participation standards, effectively giving a seal of approval to health plans sold through the exchange. This will be supported by the federal requirement that exchanges develop a rating system for plans and provide consumers with information on plans' ratings based on their quality and price. The exchange web site can provide information on all plans offered in the market, not just those available through the exchange. Allowing consumers to make meaningful comparisons across plans will help them see how exchange based plans offer superior value and quality to members.

Participation Inside and Outside of Exchange. The federal law does not eliminate the insurance market outside of state exchanges. While not specifically addressed in the law, some analysts read the law as leaving the option of doing so to state discretion. This would have the benefit of ensuring a larger pool of enrollees in the exchange and eliminating risk selection between the exchange and outside markets. However, it would also mean that undocumented immigrants would not be able to purchase insurance at all. This would undermine the goals of insuring all residents of Oregon and greatly reducing the cost shift now experienced by the insured whose premiums subsidize "free" care for the uninsured.

Assuming the existence of an exchange market and an outside market, the question then rises of whether plan participation in the exchange should be assured by requiring all carriers wishing to sell health insurance in Oregon to participate in the exchange. If a carrier has to participate in the exchange in order to also sell in the outside market, a plan that fails to get certified for exchange participation would effectively not be available in the outside market either. Whether this is a positive or a negative outcome depends on your perspective. Requiring carriers sell both inside and out could mean that some carriers leave Oregon entirely. This would reduce consumers' carrier and plan choice. However, such a rule could protect consumers against carriers that enter the market in order to attract low risk enrollees without providing a quality benefit. Carriers in the exchange will offer plans at multiple coverage levels. A plan seeking to cherry-pick low risk enrollees by only offering a bronze level plan would not be accepted into the exchange, and thus would effectively be excluded from the Oregon market. Meaningful choice could be retained while protecting consumers from "bottom feeders."

The Healthy Kids program provides a model for how the exchange could function. Healthy Kids included all health plans that met the program's qualifications. The goal was to have two statewide carriers and to give all enrollees a choice of at least two plans.

State Flexibility to Adjust Standards. Allowing voluntary participation by insurance carriers gives the exchange more flexibility to establish quality and other participation criteria, and to adjust those criteria as needed. A plan that fails to meet set standards can be taken out of the exchange without disrupting coverage for people purchasing the coverage in the outside market. Another way to protect consumers from such carriers will be discussed in Recommendation 11 (Minimum Standards for Plan Offerings).

Meaningful Variation and Useful Navigation. There is a tension between standardization and innovation. Variation for its own sake causes confusion, and simplification is one of the Board's stated goals for an exchange. The exchange should encourage rather than limit health delivery innovation in areas such as payment models, delegation of authority and medical home. Rather than limit carrier choice, the group talked about ways the exchange could make it easier for consumers to figure out what plans best meet their needs. In Massachusetts, the Commonwealth Connector utilizes a web site that allows plan comparison by geography, price and benefits. Additional navigation functions could be built in to Oregon's tool. The screening tool could help users to navigate choices by asking them the questions they might not know to think about when choosing a plan, such as network participants or care coordination services.

The group also recognized that depending on the area of the state, the issue may be too much choice or not enough of it. In addition, it can be difficult for people to judge future medical need, so making choices about what plan will be best over time can be challenging.

At the plan level the goal is to offer adequate choice in all areas of the state and ensure the consumer's ability to navigate the options and make meaningful choices. In the longer term, the exchange may want to change the rules based on the experience seen over time. To this end, the exchange must have statutory authority to change carrier participation rules in light of experience showing that such changes are needed.

Establish "High Value" Designation. One area to explore is the suggestion by an exchange technical advisory work group member that the exchange could selectively contract with one or more carriers that participate in the exchange. Specific health plans could receive a "preferred" or "high value" designation based on their adherence to higher quality and cost standards. This could encourage other carriers to improve quality over time in order to meet the higher standards and get the quality designation.

Recommendation 9: Young Adult/Catastrophic Plan Will Only be Sold by Carriers Participating in the Exchange

Allow products identified as young adult plans and "catastrophic" insurance packages to be sold only by providers participating in the exchange.

Discussion

The PPACA allows for a catastrophic plan to be sold to individuals under age 30 and people with hardship exemptions from the insurance mandate. The catastrophic plan will provide coverage or the essential health benefits, with deductibles based on those allowed for HSA-qualified high deductible health plans. Deductibles will not apply to at least three primary care visits.⁹

As these plans are only open to specific categories of purchasers, it will be necessary to certify that the buyer is eligible to enroll in a catastrophic plan. This can most easily be done through the exchange. This is particularly important for individuals deemed exempt from the insurance mandate, as the exchange is responsible for granting exemptions and informing the federal government about which Oregonians are receiving exemptions. If the plans are sold in the outside market, additional coordination will be required to ensure the exchange receives the information it needs. Exempt individuals and young adults have a financial stake in the exchange providing information to the federal government, so that they can be assured that they will not be wrongly penalized for not purchasing a qualified health plan.

Offering young adult and catastrophic coverage plans through exchange-participating carriers will provide an incentive to carriers to participate in the exchange.¹⁰ As young adults tend to be healthier than the average under-65 population, this group is a lucrative market. It is also a group that has historically had high uninsurance, meaning that many Oregonians in this age group will be new entries into the health insurance market.

Recommendation 10: Set Minimum Standard for Plan Offerings Sold in Individual and Small Group Markets¹¹

As required by the federal law:

- All health plans must meet federal essential benefits requirements.
- Exemption exists for “grandfathered” plans sold before March 23, 2010.
- All companies selling insurance in Oregon will offer at least “Bronze” and “Silver” plan offerings. Carriers may also offer plans in addition to these plan levels.

Discussion

Minimum Coverage. The PPACA amends the Public Health Services Act, directing insurers to ensure that the coverage offered through the individual and small group markets includes the essential health benefits package identified in section 1302(a) of the reform law. Exemptions are made for so called “grandfathered plans” (those issued before March 23, 2010) and insurance purchased by large employer groups covered by ERISA law. In addition, young adults under age 30 may purchase “young adult plans” with higher deductibles than allowed with other coverage.

⁹ PPACA, Section 1302(c).

¹⁰ House Bill 2009, Section 17(a)(H) requires the Exchange business plan to consider strategies to maximize the participation of private insurance plans offered through the exchange.

¹¹ HB 2009 Section 1(a)(A) requires the Exchange business plan to include information on the selection and pricing of benefit plans to be offered through the exchange, including the health benefit package developed under section 9 (1)(j) of this 2009 Act. The plans shall include a range of price, copayment and deductible options.

Individuals deemed exempt from the insurance mandate due to economic hardship may also purchase these “catastrophic” packages.

Coverage Level Requirements. Oregon will need to ensure that its laws and regulations are consistent with the federal law. In addition, the state can take steps to ensure that insurance carriers do not attempt to market to low risk people by offering only the lowest cost and coverage plans. Requiring that all insurers selling coverage in Oregon offer at least the bronze and silver level plans will help avoid such a scenario.

The Bronze, Silver, Gold and Platinum coverage levels identified in the PPACA each provide coverage for a specified share of the full actuarial value of the essential health benefits (60% for bronze through 90% for platinum). The federal law requires that carriers participating in the exchange offer at least both a silver and a gold level plan. While carriers not participating in the exchange may not want to offer all plan levels, the state can require carrier to offer both bronze and silver level plans.

Recommendation 11: Set the Same Premium for Plan Sold Inside and Out of the Exchange

As required by federal law, a given plan sold both inside and outside of the exchange must be offered at the same premium in both venues.

Discussion

Section 1301(a)(1)(C)(iii) of PPACA requires that premiums be the same for a given health plan offered both inside and outside of the exchange. State law will follow the federal requirement; rates for plans offered both inside and outside the exchange will be subject to regulation by the Insurance Division, with pricing consistent inside and out.

Recommendation 12: Utilize Insurance Agents and Brokers to Help Individuals and Group Get Coverage Through the Exchange

Utilize insurance agents and brokers to help people buy insurance through Oregon’s exchange. Give the exchange the authority to appoint agents and pay them directly instead of having them paid by individual insurance carriers.¹²

Discussion

The PPACA allows states to decide whether to use agents in the exchange, directing states that do utilize them to follow certain rules. Agents are generally knowledgeable about a range of insurance products and can be helpful for individuals and groups seeking to buy insurance through the exchange. Agents can help explain the benefits of exchanges for individuals seeking to access tax credits, those not accessing financial assistance, and employers seeking to offer a range of coverage choices to their employees.

¹² HB 2009 Section 1(a)(F) “Identifying the role of insurance producers.”

Agent Education and Reimbursement. Consistent with federal guidelines, the board should have the authority to determine the manner and amount of agent reimbursement. Allow for a certification process with standards set by the exchange board for agents selling exchange products. To the extent that the exchange educates agents on exchange benefits and offerings, agents can be a useful resource to consumers and can actively help the exchange become sustainable. An educational program run by for agents by the exchange would identify agents that have self-selected on their interest and ability to represent what the exchange has to offer.

Navigators. Some agents may seek to become “navigators.” Other organizations will become navigators as well. Members of the technical advisory work group suggested that to make the best use of navigators, some of their functions could be exempt from producer licensing requirements.

D. ELEMENTS OF AN EXCHANGE – Benefits

Recommendation 13: Give the State Authority to Make Changes to Benefit Requirements and Mandates

Once the federal government lays out requirements for essential health benefits:

- The state may want to make additional requirements.
- The state should retain its authority to make changes to benefit requirements once more information is known on the federal requirements.

Discussion

House Bill 2009 Section 17(a)(A) focuses on the selection and pricing of benefit plans to be offered through the exchange. The law requires that plans must include a range of price, copayment and deductible options. This flexibility will continue to exist under federal reform.

To ensure that the exchange is responsive to needs identified over time, the Exchange board should be given statutory responsibility for establishing contract standards with an emphasis on quality, access and evidence based care. For benefits requirements that would affect all plans offered both inside and outside the exchange, the State should retain the authority to change the rules as needed. This is not an exchange role as it would affect all plans whether they were offered inside the exchange or not.

E. ELEMENTS OF AN EXCHANGE – Timing

Recommendation 14: Allow Employer Groups with 1-50 Employees in Exchange in 2014-15; Allow Groups with 51-100 Employees to Enter in 2016

- In the first two years of the exchange’s operations (2014 – 2015), enrollment in the exchange will be open to individual purchasers and employer groups with up to 50 employees.
- Eligible groups will be expanded in 2016 to include groups with up to 100 employees.

Discussion

The federal health reform law gives states flexibility to determine whether to define exchange eligible small employer groups as 1-50 or 1-100 in 2014 and 2015. In 2016 exchanges must allow entry to employer groups with up to 100 employees. Numerous market changes will occur in 2014. While many of these changes will benefit many Oregonians, they have the potential to cause disruption for others. Waiting until 2016 to change the definition of a small group will limit disruption for employer groups.

Currently the definition of a “small group” in Oregon is defined as 2-50 for insurance purposes. Small groups are governed by Insurance Division rules that do not apply to large groups. Per federal law, in 2016 the small group definition will change to include groups with 51-100 employees. This will mean changes for these employer groups and those in the 50 and under employee population. To best address and limit the impact of such changes on all employers, staff recommend waiting until 2016 to integrate the 51-100 employee groups into the small group market. This will allow for the needed time to work with insurers, employers and agents to educate them about the changes involved and assist them with any transition issues.

Recommendation 15: Consider Implementing Early if Tax Credits for Individual Market Purchasers can be Made Available Before January 2014

Investigate whether federal tax credits can be made available for individual insurance purchasers prior to January 1, 2014, possibly on a pilot basis.

Discussion

The federal health reform law provides insurance subsidies in the form of tax credits that begin on January 1, 2014. Oregon may want to investigate whether its residents could access subsidies on a state pilot basis in order to implement an exchange earlier than 2014. Subsidies for insurance purchase will be a key driver for many individual market purchasers to buy insurance through the exchange. Without access to subsidies, there is little incentive for the currently insured to change coverage, and many of the uninsured are likely to be unable to buy insurance without the support of federal tax credits.

Enrollment and Self Sufficiency. As required by the PPACA, the state exchange must become self-supporting in 2015. To do this, requires the exchange to enroll people relatively quickly. The exchange will have set costs that do not change based on the number of enrollees; more enrollees makes these costs more sustainable and lower on a per-capita basis. If the exchange can not expect a sizeable population to enroll in advance of tax credit availability, it will make the exchange hard to fund and could endanger the exchange’s ability to support itself in 2014 and beyond.

Waiting for Federal Guidance. Moving an exchange to become operational a year in advance of the January 2014 date set out in federal law reduces the time available for planning and implementation. The exchange exists within the framework of a whole set of reforms being implemented in Oregon, including the temporary federal high risk pool, risk-sharing and the

transition to a guaranteed issue market. This is particularly a concern as the state exchange will be built within federal requirements and guidance on benefits and other areas. While this information is forthcoming, there is currently no set deadline for federal guidance on these issues. It is not yet clear when federal grant dollars will be available for exchange design and implementation.

F. ELEMENTS OF AN EXCHANGE – Public Program Coordination

Recommendation 16: the Exchange Board will Develop a Plan for the Integration and Transition of Existing Public Programs and Population Groups

The Board, working with the Oregon Health Authority and the Department of Consumer and Business Services, should develop a plan for the integration and transition of various public programs currently in existence, including but not limited to the Oregon Medical Insurance Pool (Oregon’s high risk pool), the Family Health Insurance Assistance Plan, and other programs as needed.

Discussion

The exchange will work with the Oregon Health Authority and the Department of Human Services to ensure the seamless diversion to Medicaid and other programs for individuals identified as eligible for state assistance. The exchange will develop a plan for this work and will have the flexibility and authority to contract with Medicaid eligibility staff. The exchange must have the authority to make decisions that work best for the exchange and people of Oregon, taking into account what will best facilitate seamless coordination and transfer between systems.

G. ELEMENTS OF AN EXCHANGE – Risk Mediation

Recommendation 17: Work with the Federal Government to Implement Risk Adjustment Measures

Coordinating with the federal government where necessary, implement reinsurance, risk adjustment and a risk corridor.

Discussion

House Bill 2009 allows the Health Policy Board to determine the need to develop and implement a reinsurance program to support the exchange.¹³ The federal health reform law identifies three risk spreading or risk mitigation programs that will begin in 2014: risk adjustment; reinsurance; and a risk corridor. The first two will be administered at the state level, while the risk corridor will be a federal effort. The state risk adjustment program will apply to individual, small group and some large group products. The program will redistribute money from plans that incur lower than average risk to those with higher than average risk. The federal Health and Human Services Secretary will establish criteria and methods that will structure the state programs.

¹³ HB 2009 Section 17(b)(G).

The reinsurance program is for individual market plans. Although it will be administered at the state level will be based on federal standards. The risk corridor will apply to individual and small group products offered through the exchange and is based on the risk corridors used in Medicare Part D.

Reinsurance and the risk corridor will be time limited, lasting only for three years starting in 2014. Risk adjustment will be permanent. In addition, the federal government is working on a short-term reinsurance program for retirees, which ends in 2014. The state will need statutory authority to establish these mechanisms, but no decisions are needed about whether to implement these efforts.

H. ELEMENTS OF AN EXCHANGE – Funding Operations

Recommendation 18: A Fee on Premiums Sold through the Exchange will Provide Ongoing Exchange Funding

Implement a fee on plans sold through the exchange that will be paid through premiums.

Discussion

The federal government will provide states with start up funds in the form of grants for exchange development and implementation. By January 1, 2010, the state exchanges must be self-sustaining. The federal reform law allows an exchange to charge user fees or assessments to support its operations. A user fee will put the exchange in the position of earning its operating revenue by demonstrating its value to consumers and carriers. Proving its value is something that the Oregon Health Fund Board's Exchange Work Group discussed, and which will encourage efficiency in operations and contracting. To make user fees a viable support mechanism, the exchange will need to get up to scale quickly. In 2009, the Massachusetts exchange had a fee of 4% of premium, with enrollment of approximately 187,000.

The fee on plans purchased through the exchange will not increase the total cost of the plan's premium. The PPACA requires that Qualified Health Plans (those certified to be sold through the exchange) agree to sell their plans at the same price whether offered inside the exchange or outside of it.