
Oregon Health Authority
Oregon Health Policy Board



Building Oregon's Health Insurance Exchange
A Report to the Oregon Legislature

DRAFT
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EXECUTIVE SUMMARY

Mission

With the passage of the Affordable Care Act, Oregon has an opportunity to design and build an exchange that meets the needs of its residents. Oregon will develop a strong, patient-centered exchange that ensures choice, value and access. It will increase access to information for consumers, employers and others and will be developed with the help of stakeholders and the federal government. By building its own Exchange, the state has the chance to use this institution as a vehicle to promote system change at the same time it increases access to affordable, quality coverage for individual and business consumers. This Exchange will be self-supporting by January, 2015, not relying on state general fund or federal support for ongoing operations.

Value Proposition

A successful exchange will provide individual and group consumers: meaningful choice of health plans and providers; convenience, including apples-to-apples comparisons, easy shopping and choice, smooth enrollment processing and easy payment processing; excellent customer service; and clear value for the premium dollar. The Exchange will be easy to use for employers, offering administrative simplicity (consolidated billing, easy premium calculation and streamlined processing) and improved employee choice. Insurers will be able to compete on a level playing field and will have access to easy enrollment, billing and payment processing, as well as protection from adverse selection. A successful exchange will facilitate the flow of information between consumers, plans, and state and federal agencies.

Exchange Enrollment

Enrollment in health insurance coverage accessed through the Exchange will grow over the first several years of operations, rising from 142,500 in 2014 to 232,500 in 2016. An anticipated 150,000 previously uninsured individuals will gain coverage by 2019. Employee coverage is expected to grow from 65,000 employees in 2014 to 95,000 in 2016.

Operating Revenue and Expenses

As set out in the Affordable Care Act, the federal government will fund the development and implementation of state exchanges. This funding runs through December 2014, the first year of coverage accessed through the Exchange. Operating expenses for 2013 are estimated at \$37 million; 2014 expenses are \$36 million. No revenue is expected in 2013, but starting in 2014 the Exchange may assess a fee in order to become self-sustaining starting in 2015. Over the period 2014-2016, operating revenue will rise from \$31 million to \$50 million. A likely revenue source is an administrative fee based on Exchange-covered lives. This fee will be about 3% of premium (3.3% of premium in 2014, down to 2.8% by 2016). Plan expenses associated with an exchange fee will be offset by savings to health plans in marketing, acquisition and enrollment (activities the Exchange can do on behalf of participating health plans).

Next Steps

A detailed operational plan, funded by a federal grant, is currently under development. The plan, to be completed in September 2011, will be the basis of the implementation work to occur in 2011-2013.

I. BACKGROUND

A. Why This Report Was Produced

House Bill 2009 Directs OHA to Develop an Exchange Plan

The Oregon Health Fund Board's comprehensive plan for health reform influenced the shape of House Bill 2009 (HB 2009) was passed by the Oregon Legislature in 2009. HB 2009 directed the newly created Oregon Health Authority (OHA) to develop a plan for an exchange in conjunction with the Department of Consumer and Business Services (DCBS). A report on this plan was due to the Oregon Legislature by the end of 2010.

While OHA staff was developing an exchange plan, the Patient Protection and Affordable Care Act of 2010 (ACA) became law. Passed in March 2010, the ACA authorized states exchanges, established their basic functions and requirements and provided federal funding for state exchange development and implementation through December 31, 2014.

The law requires the federal Department of Health and Human Services (DHHS) to assess each state's readiness to run its exchange, certifying state exchanges by January 1, 2013. Exchanges must be operational in 2014, offering information on plan options, helping people determine eligibility for premium tax credits, and enrolling people in coverage through the Exchange.

To meet required federal deadlines, Oregon and other states must begin building their exchanges now. This process has begun with the policy and operational assessments outlined in this report; in September 2010, OHA received a 12-month grant from the federal Office of Consumer Information and Insurance Oversight (OCIO) to develop a detailed operational plan that would meet federal guidelines but tailor the Exchange to Oregon's goals and insurance market. The next step is authorizing legislation for Oregon's Exchange. The federal government will fund the development costs of the Exchange, but its operations must be self-sustaining by January 1, 2015.

Ultimately, if Oregon does not design its own state Exchange, the federal government will establish one that Oregonians will use. The federal exchange will be designed and built without Oregon input or assistance.

B. 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.

C. Recent Oregon Reform Proposals Included Exchange

Oregon Health Policy Commission: *Road Map* Recommendations

Oregon health reform proposals included the concept of a health insurance exchange long before federal reform contemplated their development. 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, quality reporting and incentives, cost controls and other value-based purchasing approaches. The exchange would reduce employer's administrative burden associated with health benefits management and offer increased employee choice by offering multiple 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 Oregon Health Fund 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.

D. Federal Health Reform

Federal Reform and Market Changes

In March 2010, the Affordable Care Act of 2010 (ACA) 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. This provision of the bill is coupled with a requirement that most U.S. citizens and legal residents get health insurance coverage or face an annual financial penalty. Guaranteed issue in the absence of this kind of requirement leads to what is referred to as an insurance death spiral: people will tend to wait until they are sick to purchase insurance, which increases costs, leading to the next healthiest group leaving. Prices increase again and so on.

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, all health insurance policies must meet the actuarial standards set for the applicable metal level plan.²

Exchange Participation. Individual market purchasers and small employer groups may use the exchange to buy insurance. 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.

Adults with household income under 133% of the federal poverty level (\$29,326 for a family of four in 2010) will be eligible for no-cost coverage through their state's Medicaid program. In addition, 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 who have 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 (in 2010, \$29,326-\$88,200 for a family of four). 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.

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

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 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 HHS 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
- 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.

While the law sets out many requirements for state exchanges, there are still many details to be worked out and many policy choices left to states to tailor the federal concept to their needs and goals. The federal Department of Health and Human Services will be offering 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.

States have a fair amount of discretion in how their exchanges look and the extent to which they attempt to impact the overall market. However, each state running an 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.

The exchange authorizing legislation to be discussed by the Oregon Legislature in 2011 will include these federally-required functions. This will help show the federal government that the Oregon Exchange is making sufficient progress to continue receiving federal support for Exchange development and implementation.

The federal health reform law prescribes some of the market rules that will affect how exchanges and state insurance markets work. The most obvious of these is the requirement that all insurance be offered on a guaranteed issue basis. In addition, the ACA requires that premiums be the same for a given health plan offered both inside and outside of the exchange.³ 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.

Timing of Exchange Development and Market Reform Implementation

In September the Oregon Health Authority received a \$1 million exchange planning grant from the federal Department of Health and Human Services, Office of Consumer Information and Insurance Oversight (OCIIO). During the one year grant period, Oregon will use its grant funds to develop a detailed operational plan. This report to the Legislature frames the issues and decisions Oregon will grapple with as it builds 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, whether sold through an exchange or in the outside market. The national requirement to obtain health insurance coverage also goes into effect on this date.

E. Oregon Health Policy Board and Exchange Development

Oregon Health Policy Board Identifies Exchange Goals

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

- Increase access to health insurance coverage;
- Change the way we pay for care;
- Simplify plan enrollment, health plan rules, state health insurance regulation, and plan designs; and
- Help contain health care costs.

³ Public Law 111-148, Section 1301(a)(1)(C)(iii).

At its May meeting the Policy Board further articulated the expectation that an exchange would be a tool that could be used to implement or facilitate delivery system change, making strides to ensure affordability for members and address health equities. This makes the operational sustainability of the exchange a focus, making it imperative that the exchange stresses adequate enrollment, ease of access, and superior customer service. Further the exchange must be developed in the context of the Triple Aim goals: improving the lifelong health of all Oregonians; increasing the quality, reliability and availability of care for all Oregonians; and lowering or containing the cost of care so it is affordable for everyone.

To ensure that this happens, in October the Policy Board recommended the development of the exchange occur in the context of the four following health reform strategies:

- Develop regional integrated health systems that are accountable for the health of the community and responsible for the efficient use of resources;
- Ensure an affordable and sustainable health system by limiting health spending to a fixed rate of growth;
- Improve the value and quality of care by aligning and coordinating the purchasing of insurance and services across health programs, including the new Oregon Health Insurance Exchange; and
- Reduce duplication and increase efficiencies by establishing common quality measures, payment methodologies, administrative transactions, and other areas where our system is unnecessarily complicated.

While these strategies affect more than just the health insurance exchange, they will also be part of the exchange development work.

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.

Health Equities Review Committee

The Health Equities Review Committee provided the following recommendations regarding the development of Oregon's health insurance exchange:

- **Require Medicaid providers to participate in the Exchange** in order to foster long-term patient-provider relationships, ensure continuity of care and eliminate income-based disparity as individuals move between the Exchange and Medicaid/CHIP Programs.
- **Create a targeted, culturally-specific marketing plan** and remove application barriers in order to ensure people are able to access the benefits for which they are eligible.

- **Require the Exchange Board and Consumer Advisory Committees to have a consumer majority**, including members from racially and ethnically diverse populations. Deliberately recruit members of diverse cultural constituencies.
- **Create standards for inclusion in the exchange that measure a provider's cultural competency** (languages spoken, diverse staff, etc).
- **Provide information in multiple languages** to minority-owned and rural businesses.
- **Implement a multi-state exchange program with Washington** in order to gain purchasing power, assure continuity of culturally competent care for communities of color and increase equity in health coverage and input into delivery system governance.
- **Create a coverage plan for extended, non-nuclear families and kinship networks** to ensure healthy outcomes for families regardless of race, ethnicity or sexual orientation.
- **Implement a health coverage policy for undocumented people.**
- **Utilize the patient-centered medical home model**, allowing multiple issues to be addressed in a single visit and reimbursement.
- **Include culturally-specific complimentary treatment and traditional ways of healing in the healthcare system** by covering traditional practices in Exchange plans.

Safety Net Advisory Committee

The Safety Net Advisory Committee offered the following recommendations regarding the development of an exchange in Oregon:

- **The Exchange must ensure options are affordable** and that people know how they can get enrolled and access services. Consider barriers to care for vulnerable populations when determining affordability.
- **Manage costs and care for users of safety net.** Provide incentives for the widespread adoption of primary care, including through the use of primary care homes that can be retained for people who move between Medicaid and the Exchange.
- **Promote community-based outreach and enrollments** efforts that capitalize on strong patient centered provider relationships. Consider involving diverse groups in outreach, enrollment, and service efforts. Clarify the role of clinics play educating patients about the Exchange.
- **Require plans within the Exchange to participate in Medicaid.**
- **Allow provider panels to reflect community needs.**
- **Exchange oversight should ensure operational performance, clinical quality and competency, and community and patient satisfaction.** The exchange should hold both payers and providers accountable.
- **Allow any Oregon resident to buy coverage** if they do not qualify for state programs.

Public Meetings with Stakeholders across the State

In September 2010, the Oregon Health Authority and the Oregon Health Policy Board held six community meetings around the state (Corvallis, Baker City, Portland, Florence, Medford, and Bend). The meetings introduced the OHA and OHPB to the public, provided an update about the progress of health reform in Oregon, and solicited public input on the overall direction of these reforms and key elements of the health insurance exchange. High level state staff and at least one board member participated in each meeting. Attendance at the meetings was strong; approximately 850 people participated in the six meetings. Participants were enthusiastic about

the opportunity to engage in discussions about the development of the state's exchange. While individuals expressed a range of views, the following themes emerged in the various meetings:

- Limited, yet meaningful choices in the exchange;
- An active exchange that exceeds minimal federal standards, although some expressed concerns that this could add a layer of regulation;
- Assure the same coverage for the whole state and make sure changes do not mean fewer choices in rural areas;
- Help people make good insurance choices;
- Provide information that help consumers compare insurance plans on things beyond just coverage options;
- Encourage competition between companies to improve insurance products;
- Think broadly about coverage and providers;
- An overall systems reform/paradigm shift less reliant on "for profit" is needed;
- Think comprehensively about reforms;
- Address the needs of rural frontier towns reliant on practitioners in other states;
- Retain the knowledge, experience and technology available from insurance agents;
- Encourage wellness-based primary care and healthy choice incentives.
- Allow for community input in the design of the exchange.

Section II of the report lays out the operational considerations for an Exchange, including the value the Exchange can offer consumers, employers, health plans and the market generally. Section III identifies the policy decisions that will be made during the planning process based on the Exchange authorizing legislation and guidance from the Oregon Health Policy Board. Analysis and further discussion of these policy issues is presented in the Appendix.

II. OPERATIONAL CONSIDERATIONS

As important as the policy decisions described in Sections II and IV will be for the successful development and administration of an exchange in Oregon, it is just as vital to understand who Exchange's customers are and what value a high functioning exchange will provide. While the exchange will fulfill the functions laid out in the Affordable Care Act, it must do more to meet the needs of consumers, participating health plans and the market as a whole.

A. A High Functioning Exchange Will Provide Value for Consumers and Others

As envisioned by the Oregon Health Policy Board, the Exchange will provide value for its customers, for participating health plans, and for the overall insurance market in Oregon. In a "parallel" market (in which consumers will have the choice to get insurance through the Exchange or in the outside market), the Exchange will flourish by proving its value to consumers, offering accessible services, including an easy process for determining eligibility for financial assistance, assessing plan options and enrolling in coverage.

The Exchange's Value for Individual and Group Consumers: Access, Choice, Service

The three key groups of consumers for Oregon's Health Insurance Exchange are individuals, small employers and the employees of these businesses. A successful exchange will provide the following for consumers:

- Meaningful choice of health plans and providers.
- Convenience, including apples-to-apples comparisons, easy shopping and choice, smooth enrollment processing and easy payment processing;
- Excellent customer service; and
- Clear value for the premium dollar.

The Exchange will make it easy for individuals to determine eligibility for individual tax credits and Medicaid/CHIP through a single portal, to choose health plans that best meet their needs, and to enroll in coverage. It will also have an easy to use process for determining eligibility for exemptions from the federal individual insurance requirement.

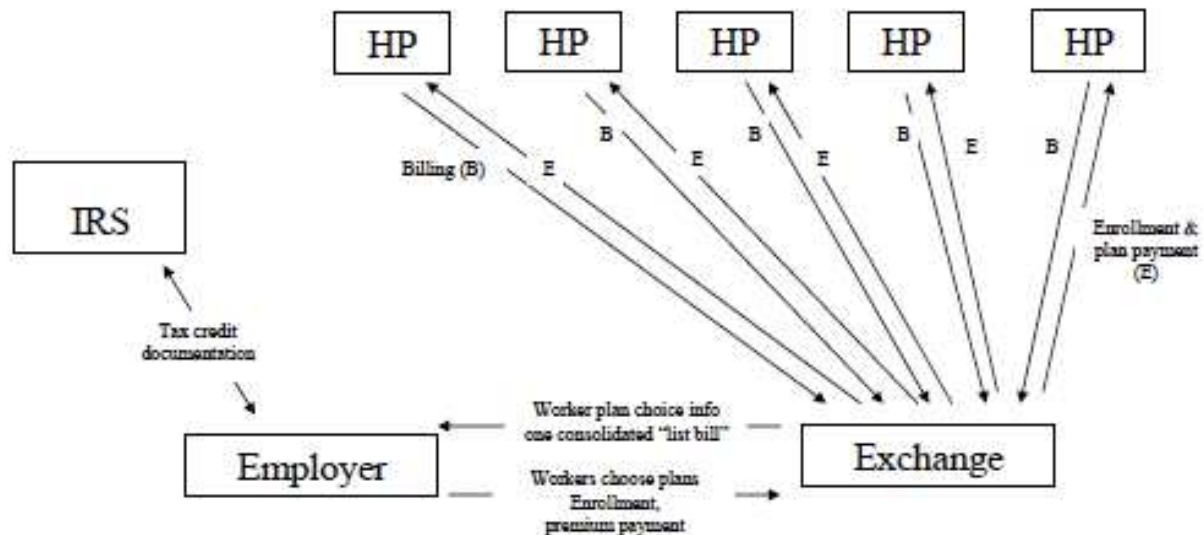
Consumers will know that plans participating in the Exchange will offer quality coverage that provides real access to care. The Exchange will establish standards for insurance carrier participation in the exchange, certifying "qualified health plans" for participation. In addition, consumers will be able to see the results of the Exchange's assessments of participating plans, giving them a better sense of the plans' performance on a variety of measures. Plan comparison will be made easy for consumers, who will be able to see plan information in a standardized format.

Consumers will have access to eligibility and enrollment information and assistance, both through the Exchange web site and through other means (including by telephone, with the help of agents and Navigators). The web site will also provide an electronic calculator that will allow users to determine the real cost of health insurance choices after tax credits and cost sharing assistance are applied. The Exchange will have a consumer complaint process that will respond to any problems with the Exchange process and will help users work through health plan issues.

Navigators, community organizations that will help people determine eligibility and enroll in coverage, will be supported with training and funding. These organizations will also conduct outreach to ensure that diverse individuals and groups across the state are aware of the Exchange and what it can offer, and understand that they may be able to get financial assistance gaining health insurance.

Value for Employers: Defined Contribution, Administrative Simplicity, Convenience

To ensure the Exchange works for employers as well as employees and individual consumers, the Exchange will be designed to make employer participation easy. Employers will be able to provide employees with a defined contribution toward their health care premiums. Employees will choose the plans that work for them and the Exchange will let the employer know the total owed and set up an administratively easy process utilizing consolidated billing. Employers will know how much to deduct from employee paychecks and will give the Exchange a single payment for the sum of all employee and employer premium contributions. The Exchange will direct the appropriate premium amounts to the health plans in which the employees are enrolled.



Source: Institute for Health Policy Solutions

Value for Participating Health Plans: Level Playing Field, Administrative Assistance.

While the individuals and groups that will purchase insurance through an exchange are the organization's main consumers, insurance carriers, brokers and state and federal agencies are also key constituents with whom a successful exchange must work smoothly. Insurers want an opportunity to compete on a level playing field, a process that facilitates easy enrollment, billing and payment processing, and protection from adverse selection. A successful exchange will make the enrollment process work smoothly for consumers and their chosen health plans, and will facilitate the flow of information between consumers, plans, and state and federal agencies.

Premium Offsets. The ACA allows exchanges to support operations through an assessment on health plans. Based on enrollment projections, the Exchange operations are anticipated to cost 3% of average premium costs. These expenses will be offset by savings to health plans. For example, the Exchange will provide administrative functions in marketing and acquisition that are now conducted and paid for by health plans. The Exchange can reduce health plans' administrative burden by conducting an enrollment function on behalf of plans.

Value to Other Stakeholders: Payment for Services, Smooth Information Transfer

Insurance brokers want the opportunity to provide and be reimbursed for services to their clients. For their part, government agencies need data exchange to work smoothly, whether the information in question is related to Medicaid or tax credit eligibility, coverage verification, income or determination of individuals' exemption from the insurance mandate.

Value to the Market as a Whole: Transparent, Comprehensive Information, Education & Outreach

The Exchange will provide value for the entire individual and small group insurance markets, including individuals who choose to purchase outside the Exchange and health plans not participating in the Exchange. All purchasers will be able to get comparable information about the health plans offered in the state, including those that do not become "qualified health plans" sold through the Exchange. The exchange will conduct public education and outreach, not just about the benefits of using the Exchange, but also about: the changes that will go into effect in 2014 (guaranteed issue coverage, individual insurance requirement, etc); how to choose and enroll in coverage; and how to use insurance to improve and maintain health.

The Exchange will be a tool to promote quality and cost effective coverage both for plans participating in the Exchange and for those offering coverage in the outside market. In addition, the exchange will conduct risk adjustment mechanisms in order to minimize adverse risk to plans participating in the Exchange.

Improving the System: Quality, Cost, Service

The Health Policy Board has indicated that it does not want Oregon's Exchange to just do the minimum required by the federal government. The Exchange is anticipated to be an active purchaser. This may be done through selective contracting, standard setting, rate negotiation, or a combination of these techniques. No matter what the Exchange board pursues, these efforts will have an impact on the work and administrative costs for an exchange and must be taken into consideration as the Exchange is built.

Enrollment Projections

Modeling indicates that exchange participation will be large enough to allow for a robust exchange in Oregon. Modeling indicates that over 140,000 individual consumers and 65,000 employees will get coverage through the exchange in 2014. Those numbers are expected to rise over the next five years, particularly on the individual side as consumers understand their options and become aware of the federal individual insurance requirement. Individual membership in the Exchange is projected to be 360,000 in 2019, with an additional 98,000 enrollees entering as members of employer groups with 1-100 employees.

Cost to Run the Exchange

Based on the membership projections, the Exchange is anticipated to cost approximately 3% of average premiums. In Oregon, the Exchange is expected to cost 3% of premium. This compares favorably to the Massachusetts "Connector," which has costs equal to approximately 4% of premium. Exchange costs include expenses for: staff salaries and benefits; appeals; marketing, advertising and communications; customer service and premium billing; enrollment and eligibility services; website development and maintenance; professional services and consulting; information technology; and facilities and related expenses.

B. What Goes into Running an Exchange

Start-up Activities

Although the Exchange will officially "start" in 2014 (coverage from health plans purchased through the exchange will begin on January 1, 2014) start-up expenses will be incurred significantly in advance that date. The federal government will provide most of the funding for implementation and year one operations expenses, although HHS has indicated that some elements that will impact existing programs (such as eligibility and enrollment solutions that will affect both exchange participants and Medicaid recipients) may require financial contributions from such programs. By January 1, 2015, the Exchange must be self-supporting.

Determining Overall Costs

The following assumptions were used in the analysis of likely costs: a dual market in which the Exchange is a public corporation acting as an active purchaser offering three to four benefit options per insurance carrier per metal level. These operational assumptions are just for illustration and have not been endorsed by the Policy Board has not endorsed these assumptions.

Fixed costs include management, marketing and communications, professional services, information technology (internal) and other infrastructure costs. Functions such as eligibility processing, health plan enrollment, premium billing and customer service are variable expense based on utilization of the Exchange. Expenses were estimated using the experience of the Massachusetts Connector for similar services.

	2013	2014	2015	2016
Membership				
Individual	NA	142,500	190,000	232,500
Small group employees	NA	65,000	87,000	95,000
Estimated Operating Revenue	0	\$31	\$42	\$50
Estimated Operating Expenses	\$37	\$36	\$42	\$48
Admin fee as a % of premium		3.3%	3.0%	2.8%

Oregon's Exchange costs will depend on membership and the organization's fixed and variable costs. Membership is forecasted using estimates made for Oregon by Dr. Jonathan Gruber of Massachusetts Institute of Technology. Individual exchange participation is projected to rise

from 142,500 in 2014 to 232,500 in 2016. By 2019, approximately 150,000 previously uninsured Oregonians will have gained individual insurance coverage.

	2015	2019
Tax credit recipients	150,000	270,000
Individual premium tax credits coming into Oregon	\$150M	\$270M
Small employer tax credits coming into Oregon	\$34M	\$29M

C. Administrative Policy Issues

The Exchange's goal is to give participants choice and value in an administratively simple way. To meet the goal of satisfying the customers, a lot of work will go on behind the scenes. Implementing the Exchange will involve the development of the following administrative decisions and activities. How well the Exchange does in implementing these items will greatly affect the overall success of the endeavor.

Insourcing/Outsourcing

While some functions will be performed by the Exchange itself, other activities may be contracted out to organizations with skills and experience conducting particular operations. Certain functions are inherently governmental and are most likely to be conducted by the Exchange itself, including:

- Establishing standards for qualified health plans;
- Certifying plans to be offered in the Exchange;
- Conducting oversight of the marketing practices of insurance plans;
- Determining individual eligibility for tax credits; and
- Determining exemptions from the individual insurance requirement.

Based on the capability of the public corporation or existing state resources, other exchange functions could be provided by contracted organizations. These functions include eligibility and enrollment processing, premium billing, customer service/call center operations, and website development and maintenance. The decision whether to conduct such activities or purchase them from a vendor may be made based on a financial analysis of the relative costs, the capability of existing state agency resources and the availability of private sector capabilities.

Procurement

As at least some important administrative activities will be conducted by contracted organizations, procurement is a critical function for the Exchange. A successful exchange must have the skills to develop business process specifications, conduct performance monitoring and engage in strong contract management.

Financial Planning and Management

Financial planning and management are necessary for all successful businesses. These capacities will be especially important as there is currently considerable uncertainty regarding key financial variables, and this uncertainty can be expected to last into the Exchange's early years of

operations. Contingency planning must be part of an overall financial planning effort. Forecasting, monitoring and the capacity for rapid response are all required skills.

Other Administrative Functions

In addition to the functions laid out above, the following will also be part of the Exchange's operations:

- Marketing and outreach
- Customer service
- Coordination and integration with other state agencies (including but not limited to working closely with the Oregon Health plan to conduct coordinated eligibility determination)

The individual and small group markets will require different administrative solutions that reflect the differences in consumer needs and market operations.

Learning from Other States

While Oregon is in many ways a leader in the development of a health insurance exchange, there are many things we can learn from other efforts as we move from planning into implementation. Watching and talking to states such as Massachusetts and Utah has taught us some important things. To begin with, do not underestimate the complexity of the resources required. Related to this, recognize that growth impacts an exchange's ability to capture economies of scale. Outreach and marketing are key to this growth.

Once you have the numbers, you need to keep them. Customer service is so important for both individuals and small employer groups. This is tied to a good eligibility determination system and process, which is complex to build and takes a long time to design and implement. The smart use of vendors and considered insourcing and outsourcing are key, as are strong and robust information systems.

POLICY RECOMMENDATIONS AND DEVELOPMENT ISSUES

A. Envisioning a Successful Exchange

A successful exchange will provide useful and timely assistance to Oregonians, improving 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.

As discussed in the introduction, to ensure Oregon's reformed health care system achieves the Triple Aim goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians, and lowering or containing the cost of care so it is affordable for everyone, the exchange should be built in the context of the four health reform strategies identified by the Oregon Health Policy Board:

- Develop regional integrated health systems that are accountable for the health of the community and responsible for the efficient use of resources. Recognize that communities hold the greatest promise for fundamental change by rationalizing the use of resources and tailoring health promotion and health care initiatives to meet the needs of their residents. Oregon's implementation of key delivery system and insurance reforms should give priority consideration to how local systems can take a leadership role in improving the care of their communities within available resources.
- Ensure an affordable and sustainable health system by aggressively limiting health spending to a fixed rate of growth. Health care cost cannot continue to rise at the current rate of growth. We must work together to develop incentives for community-wide planning that will address the rate of cost growth and the resulting disparate health outcomes among Oregonians. Oregon's public and private sectors need to work together to limit spending to a fixed rate of growth.
- Improve the value and quality of care by aligning and coordinating the purchasing of insurance and services across health programs, including the new Oregon Health Insurance Exchange. The Oregon Authority can start this effort by acting as initiator and integrator, reducing unnecessary variations between programs, delivering better health outcomes, and providing better value to Oregon's taxpayers. A publicly-accountable,

consumer focused Oregon Health Insurance Exchange will: provide useful, comparative information on health plan offerings, benefits and costs; help individuals, small employers and their employees to access insurance that meets their needs; help people access federal tax credits; and set standards for health system improvement.

- Reduce duplication and increase efficiencies by establishing common quality measures, payment methodologies, administrative transactions, and other areas where our system is unnecessarily complicated. Currently, inconsistency in how care is delivered, paperwork is processed, and information is exchanged leads to increased costs and poorer outcomes. The Oregon Health Authority and the Oregon Health Insurance Exchange will build partnerships with employers, insurers, and providers, and consumer groups to eliminate unnecessary duplication and administrative complexity. Working together, Oregon's public and private sectors can create guidelines, standards, and common ways of doing business that will increase efficiency, provide better customer service and transparency, and reduce system costs.

The Oregon Health Policy Board believes that while some elements of an exchange should be laid out in statute, many elements of Oregon's Exchange are best determined by the Exchange's governing body itself, in consultation with state policy leaders, consumers and other key stakeholders. To ensure that the needed policy design and operational planning work occur in a timely manner, the Policy Board recommends the following elements are incorporated into the Exchange design:

B. Oregon Health Policy Board Recommendations

Recommendation: Establish the Health Insurance Exchange as a Public Corporation

Oregon's health insurance exchange should be a public corporation chartered by state statute.⁴ 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.

Discussion

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.

⁴ 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.

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: Establish a Health Insurance Exchange Governing Board

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:

- Oversees the implementation, administration and sustainability of Oregon's health insurance Exchange.
- Is broadly representative and includes 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, as well as a member of the Oregon Health Policy Board.
- 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.

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 quarterly or more as needed. Initially the board is likely to need to meet once or 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.

Consumer Advisory Committee. The Exchange governing board should establish one or more stakeholder advisory committees. This committee should include consumers purchasing individual insurance through the exchange, small businesses using the exchange, insurance brokers who assist small businesses, and participating carriers. Establishing one or more such

groups 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.

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.

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.

C. Policy Issues: For Additional Development

In addition to the policy recommendations outlined in Section II, building Oregon's Health Insurance Exchange will require detailed operational planning based on a number of key policy decisions. These policy issues are outlined below. Additional information and analyses on these issues is provided in the Appendix.

1. Governance

- Develop a clearly articulated mission that guides the work of the Exchange and signals to consumers and business that the exchange exists to improve access and services for them.
- Determine the membership of and roles for the Exchange's governing board and the consumer advisory groups that will advise them.

2. Organizational Structure

- Determine whether to establish the Exchange as one organization with individual and small group product lines, or as two separate organizations.
- Determine whether to utilize one Exchange that services the whole state, or two build several exchanges each serving a different region of the state.

- Determine whether Oregon will pursue its own Exchange, build a multi-state exchange or pursue other opportunities for partnerships with other states.

3. Exchange Operations

- Determine whether to establish the Exchange as the only place for individuals and small groups to purchase insurance coverage or whether to establish parallel markets inside and outside of the Exchange.
- Assess how to ensure carrier and plan participation provides meaningful consumer choice.
- Determine which carriers may sell young adult/catastrophic insurance plans.
- Establish the minimum standards for plan offerings sold in the individual and small group markets.
- Decide how insurance agents and brokers will participate in the exchange.

4. Benefits

- Determine the ways in which the state can make changes to benefit requirements and mandates as needed over time.

5. Timing

- Determine when Employer Groups with 51-100 Employees will Gain Access to the Exchange.
- Identify the circumstances under which the state would implement its Exchange early.

6. Coordination with Public Programs

- Determine how Existing Public Programs and Population Groups will be Integrated and Transitioned into the Exchange

7. Risk Mediation

- Determine how to Work with the Federal Government to Implement Risk Adjustment Measures

8. Funding Operations

- Determine how to fund Ongoing Exchange Operations

IV. NEXT STEPS IN EXCHANGE DEVELOPMENT

Oregon is currently starting to develop its Exchange plan. The state received an Exchange Planning Grant on September 30, with funding available through September 29, 2011. The work has begun with the identification of the policy and operations issues that must be developed and the many decisions that will be made over the next year. A state Exchange Steering Committee was established for the grant, and this diverse group of health and human services leaders will continue to assist the Exchange team throughout the development process by identifying needs, resources and goals, and by providing leadership and support in their various divisions and agencies.

At the end of October, the Office for Consumer Information and Insurance Oversight announced a grant to support the development of the Exchange's information technology solution. Five states or consortia will be funded under this grant, which will provide development and implementation funds for grantees' effort to build an eligibility and enrollment system for the Exchange. As this work will also benefit Medicaid, some expenses will be shared by Medicaid on a cost allocation basis. OCIIO and the Centers for Medicare and Medicaid Services recently announced that the Medicaid expenses for this work may be matched "90-10" by the federal government, meaning that 90 cents on the dollar will be paid by the federal government for eligibility and enrollment system development.

The Oregon Legislature is expected to take up an Exchange bill in the 2011 session. This bill will be the authorizing legislation under which an exchange will be established in the state. The bill will authorize the Exchange to conduct the functions required for exchanges by the federal Affordable Care Act.

In early spring 2011, Oregon will apply for Exchange implementation funds. These funds will support the development and implementation of an Exchange in Oregon based on the work done under the Exchange planning grant.

In late 2012, OCIIO will determine whether the state's exchange planning and implementation work is sufficient to allow the Exchange to allow Oregonians to buy coverage through the exchange. If OCIIO signs off on Oregon's Exchange, a consumer information and marketing campaign will occur in 2013, with an open enrollment planned for mid-year. Coverage in plans purchased through the Exchange will begin January 1, 2014.

Funding from the federal government will continue through December 31, 2014, the end of the first year of the Exchange's operations. At the end of this period each state exchange will need to be self-sustaining.