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February 4, 2008

The Honorable Peter Courtney
Senate President
Oregon State Senate
State Capitol
Salem, Oregon 97301

The Honorable Jeff Merkley
Speaker of the House
Oregon House of Representatives
State Capitol
Salem, Oregon 97301

Dear President Courtney and Speaker Merkley:

The enclosed report, "Health Insurance Exchanges and Market Reform," was prepared pursuant to Senate Bill 329 (Chapter 697 Oregon Laws 2007) and is submitted to the Legislative Assembly on behalf of the Oregon Health Fund Board ("Board").

SB 329 directs the Board to present a plan for the design and implementation of a health insurance exchange. The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report describing the current work of the Board's Finance Committee and Exchange Work Group. Given the complexity of the issue and the time available since organizing the work of the Board, this report provides background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

I hope this report will be useful to the 2008 Legislative Assembly Special Session. An electronic version of the report will be available at the Board's website: www.healthfundboard.oregon.gov.

Sincerely,

Barney Speight
Director

# HEALTH INSURANCE EXCHANGES AND MARKET REFORM

## Introduction

This report to the 2008 Oregon State Legislative Assembly Special Session is prepared pursuant to Senate Bill 329 (Chapter 697, Oregon Laws 2007).

SB 329 directs the Oregon Health Fund Board ("Board") to present a plan for the design and implementation of a health insurance exchange ("exchange"). The Board has asked its Finance Committee and a special work group of that committee to develop a range of policy options relating to the organizational structure, authority and role of a health insurance exchange.

This report does not provide the full scope of analysis and recommendations envisioned in SB 329. It is provided as an interim report, describing the *current* work of the Exchange Work Group and Finance Committee, rather than offering a set of recommendations from those groups.

As noted below, an exchange is one element, albeit an important one, of a comprehensive reform plan. Given the complexity of the issue and the time available since organizing the work of the Board, the objective of this report is to provide background information about health insurance exchanges, possible alternative missions and a summary of the work that lies ahead.

Additionally, this report focuses primarily on a health insurance exchange in the context of reforms to the individual insurance market. Just as an exchange can have benefits for people seeking insurance in the individual market, it can also assist small employers and their employees. Once the Board develops the parameters for an exchange in the individual market, a second phase can more fully analyze the benefits and development issues of an exchange for the small group market.

## Overview

### An Important Element of Comprehensive Reform

With health insurance becoming increasingly inaccessible to millions of Americans, many states are exploring a wide range of options to bring their citizens into the health care system. Several jurisdictions are considering using a health insurance exchange to assist in reaching that goal.

Health insurance exchanges function as market organizers, facilitating the purchase of health insurance. Exchanges have the most obvious benefits for individuals without access to employer-sponsored coverage. In addition, they could also potentially serve segments of the business community that provide group health insurance to their employees.

### Benefits of an Exchange

A health insurance exchange can offer a range of services with commensurate benefits. It can provide individuals with purchasing advantages similar to those of large groups. An exchange offers consumers an easy way to shop for and enroll in coverage. When combined with other

policy initiatives, it may also be used to extend tax advantages to individuals not enrolled in employer-sponsored plans. It offers access to continuous, portable coverage and provides a mechanism to aggregate premium contributions from multiple sources. An exchange simplifies administrative functions for users and can serve as a mechanism for administering public subsidies to low and moderate wage individuals and families. For small employer groups, an exchange can provide access to a larger range of plan options than are usually available to small groups. Lastly, an exchange can utilize value-based purchasing strategies that align with similar initiatives by state health care purchasing programs (e.g., Oregon Health Plan, Public Employees Benefits Board) and the private sector to improve the quality and efficiency of Oregon's delivery system.

**Previous Attempts to Run Exchanges**

Health insurance exchanges have existed in various forms over the years, including the Health Insurance Purchasing Cooperatives (HIPCs) of the early 1990s. Many HIPCs failed due to regulatory differences inside and outside of the cooperative. Where benefits, enrollment or other rules differed between the purchasing cooperative and the general market, HIPCs tended to attract higher cost, higher risk enrollees, creating a financially unsustainable situation.

Purchasing cooperatives often found it difficult to attract enough members to maximize efficiency and purchasing power. To increase membership, the cooperatives sometimes offered benefits that appealed especially to higher risk enrollees. Some HIPCs collapsed due to the financial losses associated with an "adverse selection spiral" in which expensive enrollees lead to higher premiums, causing lower risk enrollees to leave, further raising the proportion of high risk enrollees (and increasingly higher premiums).

**The Massachusetts Connector**

The most recent example of an operational health insurance exchange is the Commonwealth Health Insurance Connector Authority (the "Connector") in Massachusetts. The Connector was established as part of a comprehensive health reform initiative adopted by the Massachusetts legislature in 2006. The Connector is central to the Massachusetts market reforms and new public subsidy programs. The reforms include:

- An individual mandate;
- Merger of the individual and small group markets;
- Expansion of the state's Medicaid program; and
- Premium subsidies for low- and some moderate-income people.

The Connector administers public subsidies for health insurance premiums, and manages programs for both subsidized and non-subsidized purchasers.

The Connector administers two programs: Commonwealth Care and Commonwealth Choice. Uninsured individuals with incomes below 300% of the federal poverty level and no access to employer-sponsored coverage can access free or subsidized insurance through Commonwealth Care. For the first three years of the reform, only Medicaid-style plans run by groups that previously participated in the state's free care program may offer coverage to Commonwealth Care enrollees.

Commonwealth Choice offers access to non-subsidized commercial products for individuals with incomes above 300% FPL, as well as for small businesses. Commonwealth Choice plans are offered by insurance carriers participating in Massachusetts' commercial insurance market. Use of the Connector is voluntary, but it is the sole entry point to the health care system for individuals seeking public subsidies.

The Massachusetts reform includes an individual mandate. In order to comply with the mandate, all individuals must have health insurance that meets a minimum coverage benchmark. All plans offered through Connector meet the standard for "minimum creditable coverage".

The Connector offers a range of plan levels, with the most comprehensive, highest cost plans designated as "Gold" level. Silver plans are actuarially 80% of Gold plans, and Bronze plans are actuarially 60% of Gold. Bronze plans meet the minimum creditable coverage requirements. Within each level, all of the benefit plans are actuarially equivalent as well. Premium costs vary by plan level, with Gold plans costing the most. Bronze plans have the lowest premiums, but include higher cost-sharing for services. Young adults (up to age 26) may purchase either a Gold, Silver, or Bronze plan, or a "young adult" plan with reduced benefits, lower premiums and other differences in cost sharing, such as higher out-of-pocket limits and lower annual benefit limits.

## The Oregon Market

While it is useful to understand the Massachusetts experience as Oregon considers options to increase access to affordable insurance for all Oregonians, the insurance markets in Oregon and Massachusetts differ. Due to these differences, Oregon should not simply import Massachusetts' design for a health insurance exchange. The Massachusetts experience in designing and implementing the Connector can be instructive, but not definitive for Oregon.

**Oregon's Insurance Markets Differ from Those in Massachusetts**

It is important to understand the similarities and differences between Massachusetts' individual and small group markets prior to reform and Oregon's current markets. First, the Massachusetts population is almost twice that of Oregon (in 2006, 6,437,193 versus 3,700,758). Massachusetts' pre-reform uninsurance rate was one of the lowest rates in the nation at 7% in 2006, compared to 16% in Oregon. Also, of the 500,000 individuals in Massachusetts that were uninsured prior to reform, 40% had incomes above 300% FPL, while in Oregon, only 25% have incomes at that level.[1] Thus, prior to its reforms, Massachusetts had both a lower uninsured rate, and of those who were uninsured, a larger percentage of the population had higher incomes. (See Appendix 2 for more on Oregon's uninsured by income.)

Before its reforms were implemented, Massachusetts' individual market was smaller and less robust than Oregon's. Prior to reform, Massachusetts had 42,500 enrollees (less than 1% of the state population) in its individual market, while Oregon's individual market has 218,000 participants (6% of the state population). Massachusetts' individual market was small and relatively expensive. This was a function of numerous regulations (including guaranteed issue

[1] In 2008, 100% of the federal poverty level is $17,600 for a family of three.

without an individual mandate) that caused premiums to be significantly more expensive than Oregon's, making it attractive to only those with significant health issues and discretionary income.

Compared to Massachusetts, Oregon has a relatively large individual market with high carrier participation. However, the market has an increasing rejection rate, and individuals who enter the individual insurance market do not bear much of the cost of covering enrollees in the high risk pool.

Prior to reform, Massachusetts had a 700,000-person small group market (11% of the state population), compared to Oregon's 283,000 people (8%). Massachusetts permitted "groups of one" to buy into the small group market while Oregon regulations defined the market as groups of 2 to 50 employees.

Looking at the relative combined size of the markets that might be included in an exchange, Oregon's market is larger than Massachusetts'. On a relative scale, a health insurance exchange could impact a larger percentage of Oregon's population than the Connector does in Massachusetts. (See Appendix 3 for more information on Oregon's individual and small group markets.)

**Insurance Regulations**

From a regulatory standpoint, Massachusetts differs from Oregon as well. Both before and after reform, Massachusetts had guaranteed issue and guaranteed renewability in both its individual and small group markets. "Guaranteed issue" means that any person who applies for health insurance must be issued coverage, without regard to the individual's health status. "Guaranteed renewability" requires that once an individual is covered, the insurer can not discontinue coverage due to the individual's health status or health care use. Oregon has guaranteed renewability in both markets but has guaranteed issue only in its small group market.

Both Massachusetts and Oregon have adjusted community rating in the individual market, with rating permitted by age. Community rating is a method of calculating health plan premiums that uses the average cost of actual or anticipated health services for all subscribers within a specific group. Adjusted community rating allows carriers to base a premium on an enrollee's geographic location, family composition, and age, but the medical claims history of an enrolled individual cannot be considered. A person at age 50 will pay more than a 25-year-old because of the higher average health care costs of the older group. A 25-year-old with high medical claims will pay the same as a healthy 25-year-old and less than a healthy 50-year-old.

Prior to its reform, Massachusetts had a 2:1 rate band in the individual market, meaning that the premium charged to an older individual could not be more than twice the premium for a younger individual. This, combined with guaranteed issue but no coverage mandate, led to high costs in the individual market. This combination also led some insurers to abandon the individual market, leaving fewer coverage choices for people seeking insurance there. As part of its reform, Massachusetts combined its individual and small group markets, with a 2:1 rate band for the new, combined market.

Unlike Massachusetts, Oregon does not have restricted age bands in the individual market; the premiums for each age range represent the actual average cost of health care of persons within the age band. In the small group market, however, starting in 2007, Oregon is phasing in rate bands of 3:1 based on geographic region, family composition, age and other factors. This means that the premium charged to the highest-cost group cannot be more than three times that charged for the lowest-cost group. As in the individual market, premiums paid by small groups are not based on the group's actual claims costs but on the average cost for groups with similar characteristics.

Massachusetts' design and implementation choices are worth considering, but given the differences in the market and regulatory environment in the two states, Oregon must approach these policy issues somewhat differently than Massachusetts. The characteristics of the Oregon market, along with information on key design and implementation factors of any exchange, must be considered in the development of an exchange in Oregon.

## Role of an Exchange in Broader Reform

A health insurance exchange is a tool that works well in conjunction with other market reforms, but on its own it will not affect increased access for the uninsured. For an exchange to be effective, it should be accompanied by other key market reforms.[2] Several of these reforms form the backbone of the Oregon Health Fund Board's assumptions that underlie the group's work, including:

- Individuals must be required to have coverage (an "individual mandate"). Such a requirement ensures that healthy as well as sick people get insurance coverage. It also significantly alters the current individual market, which is voluntary. Compliance with an individual mandate would be enforced through incentives and penalties.
- Premium subsidies must make insurance premiums affordable for low and moderate income Oregonians. Subsidies paired with a mandate allow lower income individuals to acquire and retain coverage. In addition, the aggregate premium subsidies provided by the state for essential benefits must be sustainable.
- To assure that Oregonians can access insurance, the individual market must either implement guaranteed issue and renewability, or bolster the current high risk pool to allow it to absorb a large number of new enrollees. Without such changes, individuals with greater than average medical needs will not be able to comply with the mandate.

Underlying these market reforms is the assumption that consumers are offered a range of affordable plans with benefits that are attractive to them. An effective exchange will offer a choice of carriers and products, so that health plan offerings are affordable, consumer-valued and sustainable to the system's various payers.

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[2] *A Consumer Guide to Creating a Health Insurance Connector*, Christine Barber and Michael Miller. Community Catalyst. July 2007.

In order to ensure affordability and that insurers participating in an exchange do not disproportionately enroll high cost individuals, any regulatory changes imposed must apply both inside and outside of the exchange. Mechanisms must be in place to protect insurers that do enroll high-risk members, such as risk adjustment formulas or reinsurance.

An effective health insurance exchange must offer meaningful choice of health plans within reasonable standardization of benefit offerings. The exchange must provide transparent information on cost, quality, and service for consumers. If implemented in conjunction with these reforms and guarantees, a health insurance exchange can be an important element of the state's comprehensive reform plan.

**Exchange Work Group Efforts: Issue Identification and Exchange Options**
Starting in November 2007, a Work Group of the Oregon Health Fund Board's Finance Committee has been discussing options for market reforms, goals for a potential health insurance exchange and key elements of such an exchange's structure, roles and functions.

The Work Group has identified a number of potential goals for an exchange:

- **Help Consumers Shop for Insurance**: by providing consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.
- **Make it Easy for Consumers to Enroll**: by providing an efficient and user-friendly mechanism for enrollment in health plans.
- **Help Consumers and Insurers with Payment Processing**: by providing a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.
- **Help Consumers by Offering Customer Service**: by providing information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.
- **Encourage Carriers to Participate in the Exchange:** by streamlining the marketing and enrollment functions and by protecting carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.
- **Make it Easy for Consumers to Compare Options:** by standardizing or categorizing benefit plans offered by carriers.
- **Offer Choice to Consumers:** by ensuring that consumers have a choice of multiple carriers, providers and delivery systems.
- **Encourage Innovation and Improvements in the Quality and Efficiency of the Delivery System:** for example, by establishing standards for carrier participation, evaluating carriers and their provider networks, encouraging healthy competition based on quality and efficiency.

- **Encourage Innovation and Improvements in Insurance Administration:** through innovations in provider payment, incentives for efficient administration and effective customer service.
- **Maximize benefit of state-funded subsidies:** by ensuring that taxpayer dollars are deployed to obtain the best value.

While the work of the Exchange Work Group continues, the group has indicated that, of the 574,000 uninsured in Oregon, an exchange could assist an estimated 150,000 – 200,000 currently uninsured individuals who would enter the individual market as a result of an individual mandate and premium subsidies.[3] Toward this end, an exchange can enhance these consumers' ability to shop more effectively and efficiently for health coverage. An exchange could function at a number of levels in the individual insurance market.

## Options for Exchange Functions

The following list outlines a range of exchange functions in three tiers: information, enrollment and administration; benchmarking and standard-setting; and rate negotiation and selective contracting. An exchange could be configured to provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

### Tier 1: Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans.
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.
- Assist employers and others (as permitted by law) to set up and administer Section 125 plans to allow certain individuals to qualify for tax-exempt health benefits, e.g., employees who work for employers not offering health benefits.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.

[3] Many of the currently uninsured will gain coverage through Medicaid or employer-sponsored coverage. An estimated 174,000 uninsured are below the federal poverty level and would be eligible for coverage through an expanded Medicaid program. For the uninsured at higher income levels, many would have access to coverage through their own or a family member's employer. Over 80% of employers offer insurance to at least some employees.

- Provide post-enrollment customer services, e.g., provide information, support, advocacy and referral for questions regarding benefit interpretation, claims payment and other issues.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

**Tier 2: Benchmarking and Standards**

- All of the functions listed in tier 1, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information).
- Establish the role, functions and appropriate compensation for health insurance agents and brokers servicing the exchange and its customers.
- Innovate by contracting for complete packages of products and services from the carriers or allowing the exchange to contact separately for benefits or services that might better achieve benchmark performance.

[Note: All carriers that meet the benchmark standards could participate in the exchange.]

**Tier 3: Rate Negotiation and Selective Contracting**

- All of the functions listed in tiers 1 and 2, plus:
- Solicit bids or price proposals.
- Negotiate prices and/or discounts with carriers.
- Select which carriers would participate in the exchange.

In addition, health care reforms will need to be enacted that address the following:

- Design mechanisms to protect insurers who enroll high-risk members both inside and outside of an exchange (for example, risk adjustment or reinsurance).
- Establish market regulations to avoid the exchange attracting a disproportionate number of high risk enrollees. The goal is to avoid an adverse risk spiral, in which enrollment of many high risk members increases plan costs, leading to a premiums increase, which chases away more low risk members, thereby again increasing costs and premiums until the program collapses.
- Establish a process to confirm eligibility and administer subsidies for low-income individuals.

The Exchange Work Group has identified the following issues as important to the development of a functional and sustainable exchange. The group is currently working on recommendations in these issue areas:

- Exchange Design
  - What should be its roles and functions?
  - Who may (or must) purchase through the exchange?
  - What entity should administer the exchange?
  - How will the costs of the exchange be funded?
  - What is the appropriate governance structure?
- Market Reform
  - Should medical screening be used to identify a high-risk pool for rating purposes?
  - How will the costs of high-risk enrollees be financed?
  - What mechanisms should be used to protect insurers from adverse risk selection?
  - How will rates and benefits be regulated?
  - How will the transition from the current market be managed to limit disruption to the existing market?
  - How can enrollment of different types of enrollees be phased in over time?
  - How will the individual mandate be enforced?

As the Exchange Work Group and the Finance Committee prepare recommendations for the Oregon Health Fund Board, they do so with the understanding that an exchange cannot be implemented in a vacuum. Without the appropriate complementary market reforms, no exchange will be viable over the long term.

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Appendix 3 Individual and Small Group Market Shares, Oregon (2005)

## Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

### Oregon Health Fund Board

**Bill Thorndike, Chair**
President, Medford Fabrication

**Jonathan Ater, Vice-Chair**
Senior Partner, Ater Wynne LLP
Vice-Chair, Oregon Health Policy Commission

**Eileen Brady**
Co-Owner, New Seasons Market

**Tom Chamberlain**
President, Oregon AFL-CIO

**Charles Hofmann, MD**
Physician

**Ray Miao**
President, Oregon Chapter, AARP

**Marcus Mundy**
President, Urban League of Portland

## Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

### Finance Committee

**Kerry Barnett, Chair**
Executive Vice President
The Regence Group

**John Worcester, Vice-Chair**
Manager, Benefits and Compensation
Evraz Oregon Steel Mills

**Andy Anderson**
CFO & Senior Vice President
Cascade Corporation

**Peter Bernardo, MD**
Private Practice, General Surgery

**Fred Bremner, DMD**
Private Practice

**Aelea Christofferson**
ATL Communications, Inc.

**Terry Coplin**
CEO, Lane Individual Practice Association, Inc.

**Lynn-Marie Crider**
Public Policy Director
SEIU Local 49

**Jim Diegel**
President and CEO
Cascade Healthcare

**Steven Doty**
President and Owner
Northwest Employee Benefits, Inc.

**Laura Etherton**
Advocate
Oregon State Public Interest Research Group

**Cherry Harris**
Labor Representative
International Union of Operating Engineers, Local 701

**Denise Honzel**
Healthcare Consultant
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission

**David Hooff**
Vice President, Finance
Northwest Health Foundation

**John Lee**
Consultant, Strategic Affairs
Providence Health Systems

**Judy Muschamp**
Tribal Health Director
Confederated Tribes of Siletz

**Steve Sharp**
Chairman of the Board
TriQuint Semiconductor, Inc.

**Scott Sadler**
Owner, The Arbor Cafe

## Appendix 1: Oregon Health Fund Board, Finance Committee and Exchange Work Group Rosters

### Exchange Work Group

**Denise Honzel, Chair**
Healthcare Consultant

**Laura Etherton, Vice-Chair**
Advocate
Oregon State Public Interest Research Group

**Kerry Barnett**
Executive Vice President
The Regence Group

**Damian Brayko**
Director, Small Group and Individual
Kaiser Permanente Northwest

**Aelea Christofferson**
ATL Communications, Inc.

**Terry Coplin**
CEO
Lane Individual Practice Assn., Inc.

**Lynn-Marie Crider**
Public Policy Director
SEIU Local 49

**Steve Doty**
President and Owner
Northwest Employee Benefits, Inc.

**Chris Ellertson**
President
Health Net Health Plan of Oregon

**Jack Friedman**
CEO
Providence Health Plans

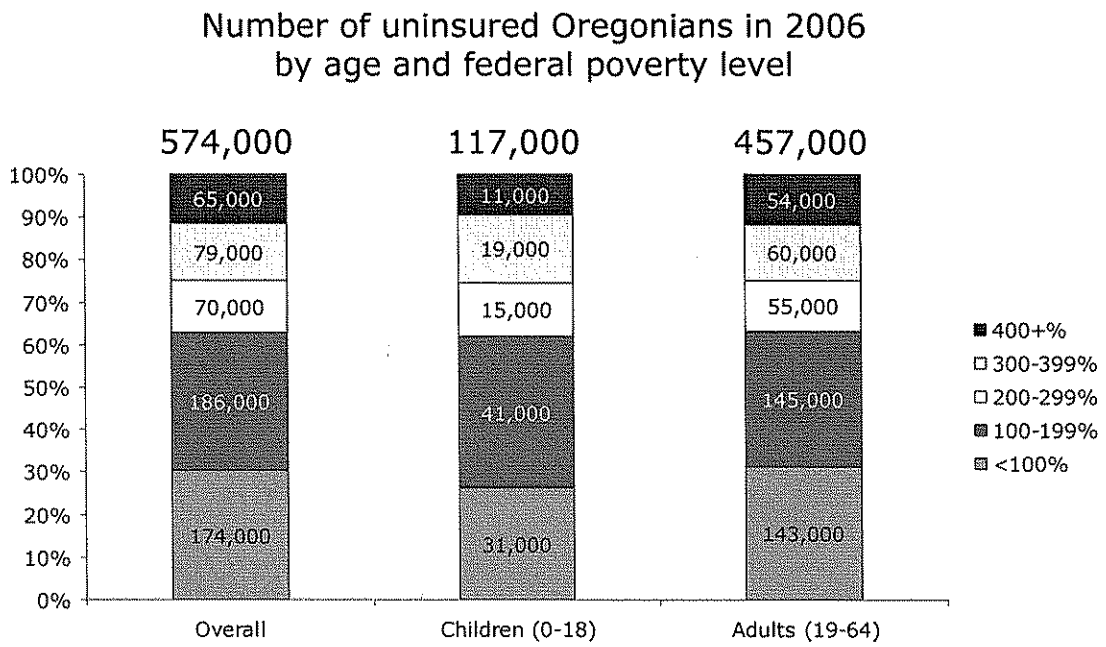
**Jon Jurevic**
Senior Vice President, Chief Financial Officer
ODS Companies

**Ken Provencher**
President and CEO
Pacific Source Health Plans

**Nina Stratton**
Owner
The Stratton Company

**Kelsey Wood**
Gordon Wood Insurance

## Appendix 2




Source: 2006 Oregon Population Survey, Office for Oregon Health Policy & Research

## Appendix 3

# Individual and Small Group Market Shares, Oregon (2005)

| | A | | B | C | D | | E | |
|---|---|---|---|---|---|---|---|---|
| | Individual Market | | Small Group (2 to 25) | Small Group (26 to 50) | Small Group (2 to 50) | | Individual + Small Group (2 to 50) | |
| Health Net | 4,642 | 2.3% | 28,856 | 10,908 | 39,764 | 15.1% | 44,406 | 9.5% |
| Kaiser | 19,373 | 9.5% | 26,722 | 5,533 | 32,255 | 12.2% | 51,628 | 11.1% |
| LifeWise | 42,238 | 20.8% | 35,965 | 5,291 | 41,256 | 15.6% | 83,494 | 17.9% |
| ODS Health | 3,511 | 1.7% | 3,082 | 2,663 | 5,745 | 2.2% | 9,256 | 2.0% |
| PacificSource | 11,232 | 5.5% | 38,833 | 8,665 | 47,498 | 18.0% | 58,730 | 12.6% |
| PacifiCare | 1,596 | 0.8% | 1,527 | 317 | 1,844 | 0.7% | 3,440 | 0.7% |
| Providence | 40 | 0.0% | 23,022 | 20,767 | 43,789 | 16.6% | 43,829 | 9.4% |
| Regence BCBS | 71,642 | 35.3% | 18,707 | 11,477 | 30,184 | 11.4% | 101,826 | 21.8% |
| Subtotal | 154,274 | 76.0% | 176,714 | 65,621 | 242,335 | 91.8% | 396,609 | 84.9% |
| Total, All Companies in Oregon | 203,000 | 100.0% | 193,000 | 71,000 | 264,000 | 100.0% | 467,000 | 100.0% |

Source: "Health Insurance in Oregon, January 2007". Department of Consumer & Business Services