

Building Oregon's Health Insurance Exchange

Appendix B: Policy Issues for Further Development **FINAL DRAFT**

INTRODUCTION

The Oregon Health Policy Board's report to the Legislature on the development of a state Health Insurance Exchange provides information on the federal requirements for an Exchange; identifies the functions and resources that will be needed for an Exchange, including the costs associated with these tasks and abilities; and highlights the policy decisions that will be worked out during the Exchange operational planning funded by a federal Exchange planning grant (October 2010 – September 2011). This appendix provides additional information and analyses on the policy issues identified in Section IV of the Health Insurance Exchange Report. The policy issues are laid out in operational categories, with discussion of options and implications provided for each item.

A. GOVERNANCE

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

Exchange Mission

The goals outlined by the Health Policy Board focus on ways of improving access and service for consumers. Facilitating access, simplifying options, enrollment and regulation, changing how services are provided, and containing costs are all intended to improve the experience of getting and keeping insurance coverage for Oregonians.

To ensure that these goals shape the development, implementation and long-term functioning of the Exchange, it will be important to have a clearly articulated, strongly held mission that guides the work of the Exchange board and executive team. This mission would also signal to individual consumers and businesses that the Exchange is working in their best interest and exists to improve access and services for them.

Board Membership

How membership is determined. Among the issues that must be addressed is the make-up of the Exchange board. Board members may be chosen for their professional and community leadership and experience or appointed based on identified constituencies. In either case, the

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board should include persons with strong backgrounds in business, consumer advocacy, health care and community service.

Ex Officio seats. There is general agreement that one way to ensure that the Exchange is responsive to and coordinated with the state agencies responsible for health care and health insurance is to include key state officials as board members. Including as voting members the Director of the Oregon Health Authority and the Director of the Department of Business and Consumer Services would provide a strong connection between the Exchange and state government. The model for including ex officio¹ members on an Exchange board is the Massachusetts Connector Authority's board. The Connector Authority includes four ex officio members: the state's Secretary of the Executive Office for Administration and Finance; Medicaid Director; Secretary of the Group Insurance Commission; and Commissioner of the Division of Insurance. In addition, a member of the Oregon Health Policy Board could be included on the Exchange board in order to ensure coordination between the two groups and provide an additional link between the Oregon Health Authority and the Exchange.

Traditionally, Oregon board members are appointed by the governor and confirmed by the state Senate. To ensure continuity over time, terms can be staggered and after the first group of appointees serves, last for four years with the potential for one reappointment for an additional four years. The governor can appoint a replacement immediately upon a vacancy.

B. ORGANIZATIONAL STRUCTURE

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

One Exchange or Two

The federal Patient Protection and Affordable Care Act requires states to build an Exchange for individual market purchasers and a Small Business Health Options Program (SHOP) Exchange. The law allows a state to combine the individual and small group Exchanges into one organization or to build two separate organizations.

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

Efficiency. The Exchange must determine whether it will be more efficient to develop a single Exchange for both populations or to build two parallel organizations, each with its own

¹ *Ex Officio* members serve by virtue of their official positions, in this case as the directors of key state departments involved in health and health care. Such members can be voting members of the board.

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population focus. The benefit of separate organizations is that each can focus specifically on its own population. However, a single organization could have two sections to fulfill the differing functions of the two product lines, while sharing similar or linked administrative and technological services. In a two organization model the two Exchanges could utilize a shared services model, though it is unclear whether this would be as efficient as building an Exchange as a single entity with two product lines.

Seamless entry and smooth transitions. Individuals may need to move between group and individual coverage due to job or other changes. The Exchange will provide increased value for consumers to the extent that it can minimize disruption of health care due to such changes. Many stakeholders have expressed a desire for transitions between individual and group coverage to be made as easily and seamlessly as possible for consumers.

Developing the technology needed to ensure simplified and seamless use of a single entity with multiple product lines will require significant financial and other resources. While the development will take some effort, the resulting infrastructure can improve access for both individual and small group insurance purchasers. This would be easier to accomplish in a single organization, but if separate individual and group Exchanges are built, special attention will need to be paid to ensuring that such transitions occur easily.

To facilitate smooth transitions, the Exchange can actively encourage participating carriers to offer both individual and group market plans. While a carrier's bronze plan for groups may not be identical to its individual bronze product, the network could remain the same across a carrier's plans. Ongoing access to providers is one of the key ways disruption is minimized for people switching between a carrier's group and individual coverage. Carriers will have an incentive to participate in both markets in order to retain individual purchasers who leave group coverage. The Exchange should facilitate smooth transitions between coverage as people move between jobs or make other changes that affect insurance coverage.

One Exchange for the Entire State vs. Several Geographically Targeted Exchanges

The PPACA allows states to operate one or more subsidiary Exchanges in distinct geographic regions of the state. While Oregon includes urban, rural and frontier areas that face different market conditions, for the most part Oregon is a single market. This is in contrast to some larger states such as California or New York that have very distinct geographic and demographic regions within a single state. While larger states could more clearly benefit from regional Exchanges, Oregon's market is statewide with some regional variation.

The general view of stakeholders is that a statewide Exchange could harness one pool of funds to provide web and phone access available statewide, but would also need to be responsive to the differing needs of consumers across the state. A final determination about whether a single statewide Exchange would work best Oregonians across the state, or whether regional sub-Exchanges could do the job better will take into consideration what will be most efficient in terms of cost and what will provide the best benefits to consumers.

Single State Exchange vs. a Multi-State Exchange

Some states and the federal government have expressed interest in pursuing multi-state Exchanges. In Oregon much of the discussion has focused on a single state Exchange that would allow the state to pursue its own policy decisions. While partnering with another state to build a regional Exchange could provide some benefits in terms of administrative cost savings, such savings are limited in terms of total dollars, and the effort to align two or more state legislatures, administrations and rules is substantial

If Oregon does pursue its own Exchange, it is worth investigating whether Oregon can partner with another state in order to save money on contracting for specific services. One area in which this could be especially useful is in information technology solutions.

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

Costs of a multi-state partnership. While sharing infrastructure development and maintenance can reduce costs, administrative costs for the Exchange are a small portion of the total costs of purchasing insurance. A one percent reduction in administrative costs would be a fraction of a percent reduction in the total cost of insurance purchase for Exchange participants. Such a reduction is not worthless, but should be considered in terms of the additional effort needed to develop and implement a cross-state Exchange. The challenges of working with two sets of state rules, legislatures, and administrations would be significant barriers to the efficient and timely development of an Exchange.

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

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

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

C. ELEMENTS OF AN EXCHANGE – Operations

Operations issues address the functional design components of the Exchange, as well as the environment that will affect those design choices.

Establish Sole Market or Dual Markets

Consistent with the requirements of federal law:

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

The federal health reform bill does not direct states to make the Exchange the sole market for individual and small group purchasers, but it leaves open the possibility for individual states to make rules about the Exchange's role in their state insurance markets.²

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

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

² In addition, House Bill 2009 allows the exchange business plan to address the issue whether the exchange should be the exclusive market for individual and small group purchasers, or whether consumers would continue to have the option of buying insurance inside and outside the exchange. *HB 2009, section 17(b)(C)*

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

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

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

How Will Benefits or Other Requirements be used to Ensure Carrier and Plan Participation Provides Meaningful Consumer Choice

The federal health reform law allows states to set insurer participation rules within the framework of the federal law and regulations on the subject. States may limit participation to carriers that meet Exchange standards and for which their participation is considered to be in the state's best interest.³ In addition, House Bill 2009 allows the Health Policy Board to establish criteria for the selection of insurance carriers to participate in the Exchange and requires the Board to consider ways to maximize the participation of private insurance plans in the Exchange.⁴

In its discussion of plan participation in the Exchange, the Exchange technical advisory work group considered the extent to which plan choice is beneficial to consumers. The group discussed how much choice is valuable and at what point having too many difficult to compare choices becomes a barrier to informed decision-making. The group was in general agreement that while choice is beneficial, it should be meaningful choice for the consumer, rather than a way for carriers to segment the market in a way that does not help consumers.

³ Public Law 111-148 (PPACA) Part II, Section 1311(e)

⁴ House Bill 2009, section 17(b)(A): "Establishing criteria for the selection of insurance carriers to participate in the exchange." Section 17(a)(H) "Maximizing the participation of private insurance plans offered through the exchange."

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Standard Setting, Selective Contracting, Information Provision. All carriers wanting to sell products in Oregon's individual and small group markets will continue to have their plan rates approved by the Insurance Division, whether the carriers sells plans inside or outside the Exchange, or both.

Federal law allows the Exchange to establish health plan certification standards for carriers seeking to participate in the Exchange. An Exchange with statutory authority to establish additional plan participation standards could define standards that are strong enough to ensure quality while not so stringent as to unnecessarily limit choice of plans. Meeting the Exchange's requirements is then up to the carriers.

Health plans sold through the Exchange could be required to meet additional participation standards, effectively giving a seal of approval to qualified health plans. This is consistent with the federal requirement that Exchanges develop a rating system for plans and provide consumers with information on plans' ratings based on their quality and price.

Another mechanism for ensuring that qualified health plans are offering value, quality and access is to provide information on the qualities the Exchange is looking for in qualified health plans. Each interested plan will provide information about its qualifications and value, allowing the Exchange to choose the plans that ensure choice, quality and value in a given geography. This may mean that the plans chosen in an area of greater plan competition are working not only to show their value but also to show that value relative to the many other plans available in the area.

To ensure consumers have information on all their options, the Exchange web site can provide information on all plans offered in the market, not just those available through the Exchange. Allowing consumers to make meaningful comparisons across plans will help them see how Exchange based plans offer superior value and quality to members.

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

If there are "parallel markets" (an Exchange market and an outside market), the question then arises whether plan participation in the Exchange should be assured by requiring all carriers wishing to sell health insurance in Oregon to participate in the Exchange. If a carrier has to participate in the Exchange in order to also sell in the outside market, a plan that fails to get certified for Exchange participation would effectively not be available in the outside market either. Whether this is a positive or a negative outcome depends on your perspective. Requiring carriers sell both inside and out could mean that some carriers leave Oregon entirely. This would reduce consumers' carrier and plan choice. However, such a rule could protect consumers against carriers that enter the market in order to attract low risk enrollees without providing a

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quality benefit. Carriers in the Exchange will offer plans at multiple coverage levels. A plan seeking to cherry-pick low risk enrollees by only offering a bronze level plan would not be accepted into the Exchange, and thus would effectively be excluded from the Oregon market. Meaningful choice could be retained while protecting consumers from “bottom feeders.”

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

State Flexibility to Adjust Standards. Allowing voluntary participation by insurance carriers gives the Exchange more flexibility to establish quality and other participation criteria, and to adjust those criteria as needed. A plan that fails to meet set standards can be taken out of the Exchange without disrupting coverage for people purchasing the coverage in the outside market.

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

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

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

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

Determine Which Carriers may Sell Young Adult/Catastrophic Plans

The PPACA allows for a catastrophic coverage plan to be sold to individuals under age 30 and people with hardship exemptions from the federal insurance mandate. The catastrophic plan will provide coverage for the essential health benefits, with deductibles based on those allowed for HSA-qualified high deductible health plans. Deductibles will not apply to at least three primary care visits.⁵

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

Offering young adult and catastrophic coverage plans through Exchange-participating carriers will provide an incentive to carriers to participate in the Exchange.⁶ As young adults tend to be healthier than the average under-65 population, this group is a lucrative market. It is also a group that has historically had high uninsurance, meaning that many Oregonians in this age group will be new entries into the health insurance market.

Determine the Minimum Standards for Plan Offerings Sold in Individual and Small Group Markets⁷

As required by the federal law:

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

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

⁵ PPACA, Section 1302(c).

⁶ House Bill 2009, Section 17(a)(H) requires the Exchange business plan to consider strategies to maximize the participation of private insurance plans offered through the exchange.

⁷ HB 2009 Section 1(a)(A) requires the Exchange business plan to include information on the selection and pricing of benefit plans to be offered through the exchange, including the health benefit package developed under section 9 (1)(j) of this 2009 Act. The plans shall include a range of price, copayment and deductible options.

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

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

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

Determine How Insurance Agents and Brokers will Participate in the Exchange

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

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

Navigators. Some agents may seek to become “navigators,” organizations trained and certified to provide assistance to people seeking to get coverage through the Exchange. Other organizations will become navigators as well. Members of the technical advisory work group suggested that to make the best use of navigators, some of their functions could be exempt from producer licensing requirements.

Determine the Ways in which the State can Make Changes to Benefit Requirements and Mandates as Needed over Time

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

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

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

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

D. ELEMENTS OF AN EXCHANGE – Timing

Timing issues includes the timing of the Exchange start up and inclusion of various populations as eligible enrollees.

Determine when Employer Groups with 51-100 Employees will Gain Access to the Exchange

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

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

Assess the Circumstances under which the State should Implement its Exchange Early

One of the key elements that may affect whether Oregon pursues an early Exchange is whether federal tax credits can be made available for individual insurance purchasers prior to January 1, 2014, possibly on a pilot basis. The federal health reform law provides insurance subsidies in the form of tax credits that begin on January 1, 2014. Oregon may want to investigate whether its residents could access subsidies on a state pilot basis in order to implement an Exchange earlier than 2014. Subsidies for insurance purchase will be a key driver for many individual market purchasers to buy insurance through the Exchange. Without access to subsidies, there is little

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incentive for the currently insured to change coverage, and many of the uninsured are likely to be unable to buy insurance without the support of federal tax credits.

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

Waiting for Federal Guidance. Moving an Exchange to become operational a year in advance of the January 2014 date set out in federal law reduces the time available for planning and implementation. The Exchange exists within the framework of a whole set of reforms being implemented in Oregon, including the temporary federal high risk pool, risk-sharing and the transition to a guaranteed issue market. This is particularly a concern as the state Exchange will be built within federal requirements and guidance on benefits and other areas. While this information is forthcoming, there is currently no set deadline for federal guidance on these issues. It is not yet clear when federal grant dollars will be available for Exchange design and implementation.

E. ELEMENTS OF AN EXCHANGE – Public Program Coordination

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

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

F. ELEMENTS OF AN EXCHANGE – Risk Mediation

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

House Bill 2009 allows the Health Policy Board to determine the need to develop and implement a reinsurance program to support the Exchange.⁸ The federal health reform law identifies three risk spreading or risk mitigation programs that will begin in 2014: risk adjustment; reinsurance; and a risk corridor. The first two will be administered at the state level, while the risk corridor will be a federal effort. The state risk adjustment program will apply to individual, small group

⁸ HB 2009 Section 17(b)(G).

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and some large group products. The program will redistribute money from plans that incur lower than average risk to those with higher than average risk. The federal Health and Human Services Secretary will establish criteria and methods that will structure the state programs.

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

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

G. ELEMENTS OF AN EXCHANGE – Funding Operations

Determine how to Fund Ongoing Exchange Operations

The federal government will provide states with start up funds in the form of grants for Exchange development and implementation. By January 1, 2014, the state Exchanges must be self-sustaining. The federal reform law allows an Exchange to charge user fees or assessments to support its operations. A user fee will put the Exchange in the position of earning its operating revenue by demonstrating its value to consumers and carriers. Proving its value is something that the Oregon Health Fund Board's Exchange Work Group discussed, and which will encourage efficiency in operations and contracting. To make user fees a viable support mechanism, the Exchange will need to get up to scale quickly. In 2009, the Massachusetts Exchange had a fee of 4% of premium, with enrollment of approximately 187,000.

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