

---

**Oregon Health Authority**  
**Oregon Health Policy Board**



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

**FINAL DRAFT FOR BOARD APPROVAL**  
**December 2010**

<b>Executive Summary</b>	3
<b>I. Background</b>	
A. Why this Report was Produced	5
B. What is an Exchange	5
<b>II. Operational Considerations</b>	
A. High Functioning Exchange Will Provide Value for Consumers and Others	6
B. What Goes into Running an Exchange	9
C. Administrative Policy Issues	10
<b>III. Policy Recommendations and Development Issues</b>	
A. Envisioning a Successful Exchange	12
B. Oregon Health Policy Board Recommendations	13
C. Areas for Further Policy Development	17
<b>IV. Next Steps</b>	19
<b>Appendix A: History and Background</b>	
<b>Appendix B: Policy Issues for Further Development</b>	

## **EXECUTIVE SUMMARY**

---

### **The Choice to be Made**

The Affordable Care Act establishes health insurance exchanges that will be run in all states. Each state may choose the federally-administered exchange run based on federal rules, or to run an exchange with state discretion within the federal framework. A State that chooses not to build its own exchange will use one that is designed and built with limited state input or assistance. In building an exchange, the state has the choice between a model with limited intervention and opportunity and an active purchaser model with greater ability to affect costs. Oregon has the opportunity to affect the cost and quality of coverage and care for all Oregonians, whether they get their coverage from the Exchange or not.

### **Mission**

With the passage of the Affordable Care Act, we have an opportunity to design and build an exchange that meets Oregonians' needs. Oregon will develop a strong, patient-centered exchange that ensures choice, value and access. It will increase access to information and affordable health insurance coverage 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 improves access to affordable, quality coverage for individual and business consumers. The federal government is financing exchange development, implementation and first year operating expenses. In 2015 the Exchange must be self-sustaining, not relying on state or federal support for ongoing operations.

### **Value Proposition**

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 successful exchange will provide value to individual and group consumers, offering: 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 for employers to use, offering administrative simplicity (consolidated billing, easy premium calculation and streamlined processing) and improved employee choice. Health 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 and Access to Federal Tax Credits**

Enrollment in health insurance coverage accessed through the Exchange will grow over the first several years of operations, rising from 142,500 in 2014 (the first year of operation) 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.

	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Individual members	NA	142,500	190,000	232,500
Small group employee members	NA	65,000	87,000	95,000

Federal tax credits will come into the state through the Exchange. In 2015, an estimated 150,000 individuals will sign up for the exchange and receive this federal premium assistance. By 2019, 270,000 individual insurance purchasers will access tax credits. These individual tax credits will be worth an estimated \$462 million in 2015 and \$922 million in 2019.

	<b>2015</b>	<b>2019</b>
Tax credit recipients	150,000	270,000
Individual premium tax credits coming into Oregon	\$462M	\$922M
Small employer tax credits coming into Oregon	\$43M	\$29M

### **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), passed by the Oregon Legislature in 2009. HB 2009 directed the newly created Oregon Health Authority (OHA) to develop a plan for a health insurance 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 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, implementation and operation through December 31, 2014.

The ACA requires the federal Department of Health and Human Services (HHS) 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 and initial operations costs of the Exchange, but its ongoing 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 significant input or assistance from states choosing not to participate in the development process.

### **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, offer an improved, modern access to Medicaid, and make it easier to enroll in health insurance.<sup>1</sup> Beginning in 2014, an exchange will be available in each state to help consumers make comparisons between plans that meet quality and affordability standards.

---

<sup>1</sup> Tax credits, which begin in 2014, will be available for individual insurance purchasers with income from 133% to 400% of federal poverty. The amount changes each year; it is \$88,200 for a family of four in 2010. Medicaid eligibility will increase to 133% of federal poverty in 2014 (\$29326 for a family of four).

## **II. OPERATIONAL CONSIDERATIONS**

As important as the policy decisions described in Section III will be for the successful development and administration of a health insurance 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. 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.

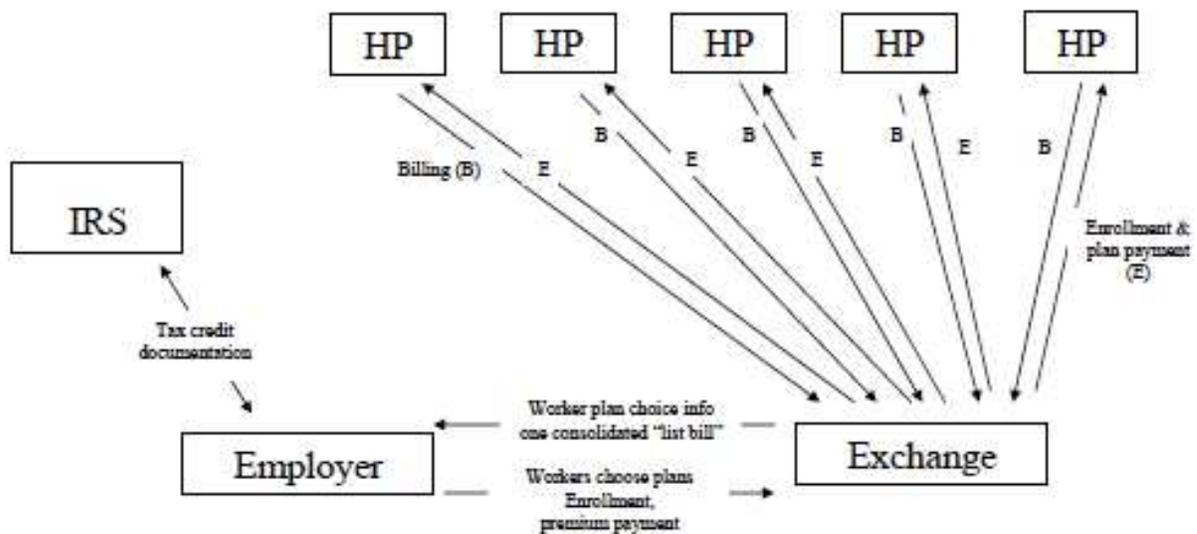
Consumers will know that plans participating in the Exchange will offer quality coverage that provides real access to care. The Exchange will establish standards for insurance carrier participation in the exchange, certifying "qualified health plans" for participation. In addition, consumers will be 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 active purchasing, 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. Running the Exchange**

**Enrollment and Tax Credit Participation**

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.

**Table 1: Estimated Exchange Membership, 2013 - 2016**

<b>Membership</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Individuals	NA	142,500	190,000	232,500
Small group employees	NA	65,000	87,000	95,000

In addition, many Oregonians will qualify for premium assistance accessed through premium tax credits. In addition, small businesses that use the Exchange will also be able to take advantage of tax credits. In 2015, tax credits worth \$505 million will come into the state, rising to a total of \$951 million entering the state for individuals and small businesses in 2019.

**Table 2: Tax Credit Recipients and Dollars in Oregon**

	<b>2015</b>	<b>2019</b>
Tax credit recipients	150,000	270,000
Individual premium tax credits coming into Oregon	\$462M	\$922M
Small employer tax credits coming into Oregon	\$43M	\$29M

**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 as the preferred model under which an exchange would work.

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.

**Table 3: Projected Exchange Revenue, Expenses and Administrative Fee, 2013-2016**

	2013	2014	2015	2016
Estimated Operating Revenue	0	\$31	\$42	\$50
Estimated Operating Expenses	\$37	\$36	\$42	\$48

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. Based on the estimated operating revenues and expenses, the administrative fee that will support the exchange is anticipated to be around 3% (starting closer to 3.3% in 2014 and decreasing to 2.8% by 2016).

### **Start-up Activities**

Although the Exchange will officially "start" in 2014 (coverage from health plans purchased through state exchanges will begin on January 1, 2014) start-up expenses will be incurred significantly in advance that date. In addition to the start up expenses incurred when any business opens, the exchange will be engaged in education, outreach and marketing starting early in 2013.

The federal government will provide most of the funding for implementation and year one operations expenses. For activities related to eligibility and enrollment solutions that will affect both exchange participants and Medicaid recipients the state will contribute 10% of the development costs (with the federal government paying for the other 90%). By January 1, 2015, the Exchange must be self-supporting.

### **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 keys 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.

### **III. 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: Create a mission-driven public corporation to coordinate purchasing strategies for all Oregonians, starting with a health insurance exchange for the individual and small group markets.**

Oregon's health insurance exchange should be operated by a public corporation chartered by state statute.<sup>2</sup> The Exchange will be accountable to the public interest but not beholden to state budget cycles. Legislation can ensure accountability of the Exchange through the establishment of a governing board, strong public participation, annual reporting, and the use of consumer advisory groups and surveys. 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.
- *Accountability/Responsiveness*: to consumers, health plans and the state.
- *Consumer Focus*: provide value and improved access for individual and group purchasers.

---

<sup>2</sup> 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.

- *Ability to work with existing state agencies:* including the Insurance Division and Oregon Health Authority.

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

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

**Accountability/Responsiveness.** Accountability can be built in to any organization, but a state agency has some inherent oversight requirements built in that ensure responsiveness to the public. 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.

To ensure accountability in a public corporation model, the statutory charter should have a strongly consumer-oriented mission statement, a board with members subject to appointment by the Governor and confirmation by the Senate, serving four year terms. Three voting ex officio members would participate by virtue of their positions as the Oregon Health Authority director, Department of Consumer and Business Services director and Oregon Health Policy Board chair. Strong conflict of interest language would ensure board members and employees are working in the interest of the Exchange and its members.

**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. The exchange mission should be explicitly consumer-focused.

**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 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 the chair 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 governing board as well.

To ensure the Exchange is accountable to its members, Oregon taxpayers, the Governor and Legislature, participating health plans and the federal government, the following should be included in the exchange authorizing statute: a strong consumer-oriented mission; inclusion of voting ex-officio members and members who use the Exchange; Governor-appointment and Senate-approval; and conflict of interest language that applies to Exchange board and staff. In addition, the exchange should be statutorily required to: establish consumer advisory groups; conduct consumer surveys to assess consumer satisfaction and exchange performance; consult with relevant state groups such as the Health Resources Commission or the Health Services Commission; be subject to ORS 243 Public Employee Rights and Benefits (as OHSU is); and collaborate with OHA, DCBS and the Employment Department for the efficient operation of all four organizations' programs.

**Board Role.** The 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 Committees.** The Exchange board should consult with and seek the assistance of consumer advisory groups. Members should include consumers purchasing individual insurance through the exchange, small businesses using the exchange, insurance brokers who assist small businesses, and participating carriers. Establishing consumer advisory 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 that state exchanges 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 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. Oregon is applying for a grant under this announcement, and expects to hear whether it is selected for this two year grant in mid-February 2011.

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.