
Oregon Health Policy Board



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

**Final Report
December 2010**

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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 using 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 Oregon's 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.

	2013	2014	2015	2016
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 Oregonians will sign up for insurance through 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.

	2015	2019
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; P.L. 111-148) became law. Passed in March 2010, the ACA authorizes states exchanges, established their basic functions and requirements and provides 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.¹ Beginning in 2014, an exchange will be available in each state to help consumers make comparisons between plans that meet quality and affordability standards.

¹ 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.

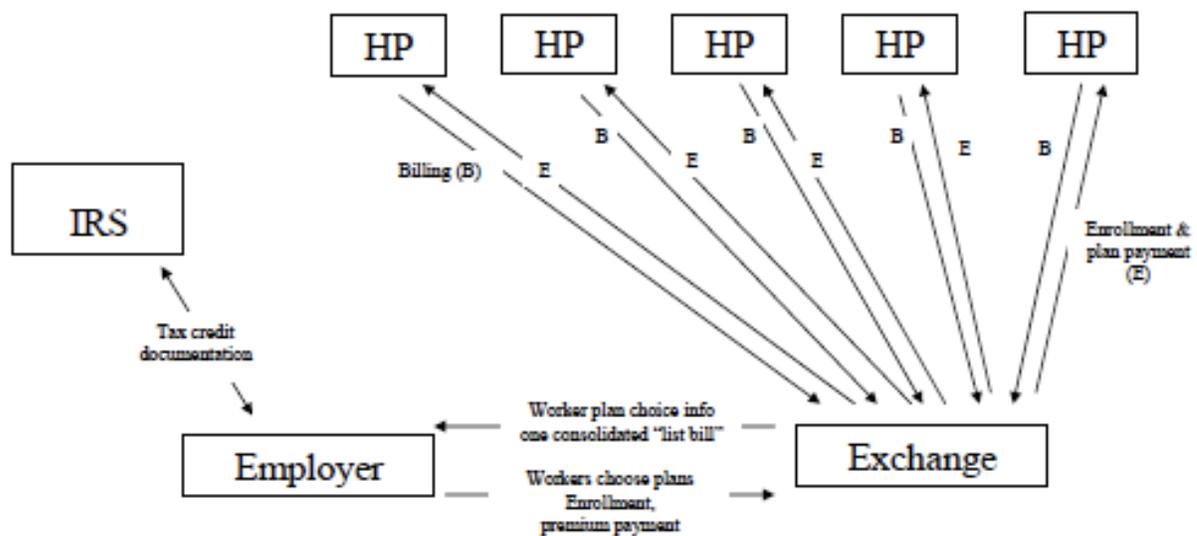
Consumers will know that plans participating in the Exchange will offer quality coverage that provides real access to care. The Exchange will establish standards for insurance carrier participation in the Exchange, certifying "qualified health plans" for participation. In addition, consumers will be 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 high level membership projections, the Exchange is anticipated to cost approximately 3% of average premiums (decreasing to 2.8% by 2016). Through 2014, the Exchange’s operations will be supported through federal funding. Starting in 2015 Oregon’s Exchange must be self-supporting.

The cost as a percentage of premium 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

Membership	2013	2014	2015	2016
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

	2015	2019
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. Final decisions on various design elements will occur during the 2011 Legislative session and through the work of the Exchange’s board.

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 and Expenses, 2013-2016

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

The 2013 and 2014 costs to run the Exchange will be paid by the Federal government. As laid out in the ACA, the Exchange must be self-supporting starting January 1, 2015.

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.

To facilitate the efficient and expedient work of the Exchange, the Exchange's authorizing statute should include the authority to engage in contracts with other entities, including state agencies and private organizations.

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 the 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

Oregon's Health Insurance Exchange, to provide value to consumers and others, must be built to be accountable to consumers, the public, the Governor and Legislature, participating health plans and other vendors, and the federal government. To ensure this accountability is built in to Oregon's Health Insurance Exchange, the Oregon Health Policy Board recommends the following be included in the Exchange authorizing legislation:

- Creation of a consumer-oriented public corporation statutorily guided by a mission statement and provisions of Oregon Revised Statutes that enhance accountability and transparency;
- A nine member Board of appointed by the Governor and confirmed by the Senate;
- Three voting ex-officio members (Director of the Oregon Health Authority, Director of the Department of Consumer and Business Services, and OHPB chair or designee);
- Exchange staff and a majority of the Governor-appointed, Senate-confirmed members subject to conflict of interest language;
- Advisory groups (individual consumers, small employers and health plans participating in the Exchange) and consultation with providers and other relevant state advisory groups;
- Annual reporting to the Governor and Legislature;
- Surveys and focus groups of consumers, navigators, agents and others;
- Exchange employees subject to ORS 243 Public Employee Rights and Benefits; and

- Requirement and authority to collaborate with OHA, DCBS, Employment Department and Revenue Department, for the efficient operation of programs.

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.² 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.
- *Ability to work with existing state agencies:* including the Insurance Division and Oregon Health Authority.

The assessment of whether Oregon's Exchange should be a public agency, a private non-profit or a public corporation model has occurred 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

² 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.

accountability and responsiveness to the public by clearly identifying these as core missions of the organization, while simultaneously prioritizing flexibility and agility as well. To ensure this, authorizing legislation may need to specify that the entity will have a consumer-focused mission.

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

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

The Exchange mission is intended to identify the Exchange as a triple-aim focused organization built and working for the benefit of its consumers. The mission was drafted with help from

members of Exchange Technical Advisory Group, and edited based on feedback from the Health Equities Review Committee.

Exchange Mission. To achieve 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: administer an exchange established in the public interest, for the benefit of the people and businesses that get health insurance coverage for themselves, their families and employees through the Exchange now and in the future.

Exchange Principles.

- The Exchange empowers Oregonians by giving them the information and tools they need to make insurance choices that meet their needs and values.
- Through its functions and in coordination with the Oregon Health Authority, Oregon Health Policy Board and Oregon Department of Consumer and Business Services, the Exchange works to improve health care quality and population health, eliminate health disparities, control costs and ensure access to affordable, equitable, quality, accountable care across the state.
- The Exchange is accountable to the public interest in all its diversity.

Exceptions to the public meetings and records rules must be included in order to protect proprietary and other market-sensitive information. It is anticipated that this will be used in very limited circumstances.

Recommendation: Establish an Exchange Governing Board with experience and knowledge in individual insurance purchasing, business, finance, consumer retailing, health benefits administration, individual and small group health insurance, and other areas to be identified.

To ensure it is well-governed, sustainable and responsive to individual and group consumers, payers, the state and other stakeholders, the Exchange will 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 Oregon Health & Science University, SAIF Corporation and the port authorities. The Massachusetts Connector Authority, which governs that state's Exchange programs, utilizes a governing Board as well.

Terms of Office. Board members will serve four year staggered terms. Of the first Board members appointed in 2011, two members' terms will expire in 2013, two in 2014 and two in 2015. The Governor may remove a Board member after a notice and hearing, but may not remove more than three members in a four year period.³ The three ex officio members and up to three other Board members may be removed by the Governor in that period. Maintaining at least three members will ensure some continuity between administrations. This is particularly important as the Exchange Board is running a business that needs to be maintained over time.

Board Role. The Health Insurance Exchange Board will focus on implementation, policy and sustainability issues. It will work closely with the Exchange executive leadership. 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.

Officers. The Board will elect one member as chair and another as vice-chair. The Board will appoint an executive director, who will appoint subordinate Exchange officers and employees.

Interim Board. Until the Exchange Board is appointed and confirmed in mid- to late-2011, the Oregon Health Policy Board can provide oversight and governance to the team developing and implementing the Exchange.

Executive Leadership Staff. 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.

Recommendation: Select Board members for their experience and knowledge. The Exchange Board will include nine members chosen for their experience and knowledge in the following areas: individual insurance purchasing, business, finance, consumer retailing, health benefits administration, individual and small group health insurance, and other areas to be identified. Six members will be appointed by the Governor and confirmed by the Senate. The appointment and confirmation process offers a public process for evaluating the competency, ethical standards and personal commitment of nominees and those being re-appointed to the Board.

³ This is modeled on the OHSU statute.

Recommendation: Include Exchange Consumers as Board Members. Starting in 2015, at least two of these members will be Exchange consumers (one an individual consumer, the other a small business using the Exchange). Until it is possible for Board members to be Exchange members in 2015, the consumer members should be individuals and small employers who will be eligible to use the Exchange. Including Exchange consumer members on the Board helps ensure that the Board's consumer-orientation is operationalized in the administration of its program.

Recommendation: Include voting ex officio members on the Exchange Board.

Three members of the Board will serve by virtue of their positions as Oregon Health Authority Director, Department of Consumer and Business Services Director, and OHPR chair (or designee), respectively. These ex officio members will be full voting members of the Board. Participation by ex officio members helps assure appropriate linkages to state health policy and insurance regulatory domains. These members can also provide valuable input to the Governor on reappointments to the Exchange Board.

Recommendation: No more than two Board members will be employed by or affiliated with the health care or health insurance industry. To ensure that staff and Board members act in the best interest of Exchange consumers, staff members and all but two Exchange Board members can not be:

- Employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health carrier or other health insurer, an agent or broker, a health care provider, or a health care facility or health clinic.
- A member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care providers while serving on the board or on the staff of the Exchange.
- A health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

In recommending the above "conflict of interest" provisions, Policy Board members were attempting to balance the need to have an Exchange board that prioritizes Exchange consumers over the needs of any health care or insurance interests with the recognition that individuals with industry affiliations may have experience and insights that are valuable to the administration of the Exchange and not available elsewhere. To allow the Exchange to benefit from the knowledge of industry-affiliated members without compromising the Exchange's consumer mission, the Policy Board recommends imposing the conflict of interest provisions on most board members, with only a minority of the Governor appointed members allowed to retain industry affiliations.

Recommendation: Ensure accountability through the establishment of consumer advisory committees. The Exchange Board will 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. Additionally, the Board should solicit input and assistance from insurance brokers who assist small businesses, participating carriers and health professionals. The establishment of consumer advisory groups encourages and facilitates 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 Exchange executive leadership.

The ACA 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.

Recommendation: Establish the Health Insurance Exchange as an organization serving individual and small business consumers across the state.

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.

Recommendation: Build a single statewide Health Insurance Exchange with individual and small group product lines. The ACA requires the development of Exchanges that serve individual and small group market purchasers. The law allows a state to combine the individual and small group Exchanges into one organization or to build two separate organizations. The Health Policy Board recommends a single organization with two product lines.

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 potential benefit of separate organizations that each focus specifically on its own population is outweighed by the efficiency gain of a single organization with two product lines that share administrative and technological services as much as is feasible.

Seamless entry and smooth transitions. Individuals often 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 will be easier to accomplish in a single

organization. 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.

Statewide Exchange. The ACA allows states to run one or more subsidiary Exchanges in various regions of the state. While Oregon includes urban, rural and frontier areas that face different market conditions, for the most part the state is a single market. This contrasts with some larger states such as California or New York that contain very distinct geographic or demographic regions. While larger states could more clearly benefit from regional Exchanges, Oregon's market is statewide with some regional variation. Most stakeholders have indicated support for a statewide Exchange that can provide web and phone access available statewide, while also being responsive to the differing needs of consumers across the state.

Recommendation: Establish an Oregon Exchange but investigate opportunities to work across state lines on procurement or other development and operations tasks.

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

Costs and benefits of multi-state partnership. A multi-state partnership could enroll a many people in a short time, spreading administrative costs over more people. Economies of scale could be expected if two states share Exchange administration. However, 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 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. Every design issue, from the structure and oversight of the Exchange through the smallest administrative rules and human resources policies would have require the approval of 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

will allow Oregon 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 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 without the complications of a multi-state Exchange, Oregon should investigate ways to partner with neighboring states on infrastructure development and other operational tasks without joint policy development and operations planning.

C. Policy Issues: For Additional Development

In addition to the pursuing policy recommendations outlined in Section B above, building an Exchange requires detailed operational planning based on a number of key policy decisions. These policy issues are outlined below, with additional information and analyses on these issues provided in Appendix B.

1. Exchange Operations

- Determine whether to establish the Exchange as the only for all individuals and small groups to get insurance, or to allow parallel markets inside and outside 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 minimum standards for individual and small group health plan offerings.
- Decide how insurance agents and brokers will participate in the Exchange.

2. Benefits

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

3. Timing

- Determine when employer groups with 51-100 workers will gain access to the Exchange.
- Identify the circumstances under which the state would implement its Exchange early.

4. Coordination with Public Programs

- Determine how existing public programs and population groups will be integrated and transitioned into the Exchange.

5. Risk Mediation

- Determine how to work with the federal government to implement risk adjustment.

6. 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 has applied for a grant under this announcement, and expects to hear whether it is selected for this two year award 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.

Building Oregon's Health Insurance Exchange

Appendix A: History and Background

Recent Oregon Reform Proposals Included a Health Insurance Exchange

Oregon Health Policy Commission: *Road Map* Recommendations

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

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

Oregon Health Fund Board: *Aim High* Recommendations

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

Access to affordable, quality health care for all Oregonians was a key Oregon Health Fund Board objective. To achieve this, the Board proposed a five-part effort to expand access to affordable health care for all Oregonians. An Exchange was proposed as the mechanism for expansion of individual insurance coverage in the state. Like the OHPC, the OHFB recommended the establishment of a Health Insurance Exchange that would help standardize and streamline administration, promote transparency for consumers, improve quality, stem cost increases for individual insurance purchasers, and coordinate premium assistance for low and middle income Oregonians. As the OHFB report was written prior to federal reform, the Board saw the Exchange as an entity that could grow over time and be used to facilitate market changes. Participating insurance carriers would be required to meet standards in: plan options offered; network requirements; adherence to standardized contract requirements based on evidence-based

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standards; transparency; common tools; and additional administrative cost and rating rule standards that could be developed by the Exchange.

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

Federal Health Reform

Federal Reform and Market Changes

In March 2010, the Affordable Care Act of 2010 (ACA) was adopted by Congress and signed by the President. The law¹ makes a number of changes to the insurance market in the United States. Starting in 2014, individual and small group insurance will be offered on a guaranteed issue basis, meaning that individuals can not be refused insurance for past or current health care use or needs. This provision of the bill is coupled with a requirement that most U.S. citizens and legal residents get health insurance coverage or face an annual financial penalty. Guaranteed issue in the absence of this kind of requirement leads to what is referred to as an insurance death spiral: people will tend to wait until they are sick to purchase insurance, which increases costs, leading to the next healthiest group leaving. Prices increase again and so on.

The federal law creates five benefit levels: bronze; silver; gold; platinum; and a plan with more limited coverage that will be available only to young adults and people exempt from the mandate to get health insurance. While the benefits in these plans are likely to be fairly similar, they differ in terms of the level of cost-sharing allowed under each. Starting in 2014, all health insurance policies must meet the actuarial standards set for the applicable metal level plan.²

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

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

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

² The one exception is for so-called "grandfathered plans," coverage issued before March 23, 2010.

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

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

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

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

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

What Federal Law Requires of Exchanges

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

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

- Basic exchange functions
- Open enrollment periods
- Minimum benefits standards for exchange products (to be defined in regulation)
- Requirement that the state exchange be self-sustaining by January 2015.
- Requirement that the exchange consult with stakeholders.

Health Insurance Exchange Report Appendix A: History and Background

While the law sets out many requirements for state exchanges, there are still many details to be worked out and many policy choices left to states to tailor the federal concept to their needs and goals. The federal Department of Health and Human Services will be offering guidance and promulgate regulations in a number of areas, including requirements for: the certification of qualified health plans; a rating system that states will use to rate plans offered through an exchange on the basis of relative quality and price, for use by individuals and employers; and an enrollee satisfaction survey. In addition, the HHS Secretary will be providing regulatory guidance on the details of the benefits package that will be considered acceptable minimum coverage to meet the individual insurance mandate.

States have a fair amount of discretion in how their exchanges look and the extent to which they attempt to impact the overall market. However, each state establishing an exchange must provide the following services:

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

Health Insurance Exchange Report Appendix A: History and Background

people who tell the Exchange they changed employers and stopped coverage during a plan year.

8. **Facilitate community based assistance** by establishing a Navigator program.
9. **Have an annual open enrollment period**, special enrollment periods, and monthly enrollment periods for Native Americans.

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

In addition to the above functions, the Oregon Health Policy board supports the inclusion of the following functions in the Exchange authorizing legislation: authority to apply for and accept grants and other funds; authority to accept premiums; and a requirement to consult with stakeholders.

The federal health reform law prescribes some of the market rules that will affect how exchanges and state insurance markets work. The most obvious of these is the requirement that all insurance be offered on a guaranteed issue basis. In addition, the ACA requires that premiums be the same for a given health plan offered both inside and outside of the exchange.³ State law will follow the federal requirement; rates for plans offered both inside and outside the exchange will be subject to regulation by the Insurance Division, with pricing consistent inside and out.

Timing of Exchange Development and Market Reform Implementation

In September the Oregon Health Authority received a \$1 million exchange planning grant from the federal Department of Health and Human Services, Office of Consumer Information and Insurance Oversight (OCIIO). During the one year grant period, Oregon will use its grant funds to develop a detailed operational plan. This report to the Legislature frames the issues and decisions Oregon will grapple with as it builds a plan that will be submitted to OCIIO in preparation for the implementation of an exchange in Oregon.

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

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

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

Oregon Health Policy Board and Exchange Development

Oregon Health Policy Board Identifies Exchange Goals

In February 2010, the Oregon Health Policy Board identified the following goals for Oregon's Health Insurance Exchange:

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

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

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

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

While these strategies affect more than just the Health Insurance Exchange, they will also be part of the Exchange development work.

Technical Advisory Group

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

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

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Health Equities Review Committee

The Health Equities Review Committee provided the following recommendations regarding the development of Oregon's Health Insurance Exchange:

- **Require Medicaid providers to participate in the Exchange** in order to foster long-term patient-provider relationships, ensure continuity of care and eliminate income-based disparity as individuals move between the Exchange and Medicaid/CHIP Programs.
- **Create a targeted, culturally-specific marketing plan** and remove application barriers in order to ensure people are able to access the benefits for which they are eligible.
- **Require the Exchange Board and Consumer Advisory Committees to have a consumer majority**, including members from racially and ethnically diverse populations. Deliberately recruit members of diverse cultural constituencies.
- **Create standards for inclusion in the Exchange that measure a provider's cultural competency** (languages spoken, diverse staff, etc).
- **Provide information in multiple languages** to minority-owned and rural businesses.
- **Implement a multi-state Exchange program with Washington** in order to gain purchasing power, assure continuity of culturally competent care for communities of color and increase equity in health coverage and input into delivery system governance.
- **Create a coverage plan for extended, non-nuclear families and kinship networks** to ensure healthy outcomes for families regardless of race, ethnicity or sexual orientation.
- **Implement a health coverage policy for undocumented people.**
- **Utilize the patient-centered medical home model**, allowing multiple issues to be addressed in a single visit and reimbursement.
- **Include culturally-specific complimentary treatment and traditional ways of healing in the healthcare system** by covering traditional practices in Exchange plans.

Safety Net Advisory Committee

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

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

Public Meetings with Stakeholders across the State

In September 2010, the Oregon Health Authority and the Oregon Health Policy Board held six community meetings around the state (Corvallis, Baker City, Portland, Florence, Medford, and Bend). The meetings introduced the OHA and OHPB to the public, provided an update about the progress of health reform in Oregon, and solicited public input on the overall direction of these reforms and key elements of the Health Insurance Exchange. High level state staff and at least one board member participated in each meeting. Attendance at the meetings was strong; approximately 850 people participated in the six meetings. Participants were enthusiastic about the opportunity to engage in discussions about the development of the state's Exchange. While individuals expressed a range of views, the following themes emerged in the various meetings:

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

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

Building Oregon's Health Insurance Exchange

Appendix B: Policy Issues for Further Development

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 recommendations of the Oregon Health Policy Board. Appendix A offers a history of and additional information on Health Insurance Exchanges nationally and in Oregon. Appendix B provides additional information and analyses on the policy issues identified in Section C 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. 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.¹

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.

¹ 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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Single Market Implications. An Exchange that is the sole market would be larger than one that would exist in the context of a dual marketplace. An Exchange as the sole market could more easily be a force for change in a marketplace in which it sets the rules for all insurance purchasers. In a split market, the Exchange can still work to improve quality and reduce costs for consumers, but its ability to do this will depend in large part on the size it achieves. A larger population within the Exchange will make it more likely for changes implemented within the Exchange to be implemented in the outside market as well. In a dual market, the Exchange must work to prove its value to consumers. Where choice is available, the Exchange must make itself the preferred option by providing the best possible products, customer service, information and support.

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

A single market would eliminate the potential for risk selection between an Exchange and outside market. With two markets, one more insurance carriers could receive unequal risk either inside 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.² 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

² Public Law 111-148 (PPACA) Part II, Section 1311(e)

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Board to consider ways to maximize the participation of private insurance plans in the Exchange.³

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.

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

³ 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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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 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

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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 or the essential health benefits, with deductibles based on those allowed for HSA-qualified high deductible health plans. Deductibles will not apply to at least three primary care visits.⁴

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.⁵ 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.

⁴ PPACA, Section 1302(c).

⁵ 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.

Determine the Minimum Standards for Plan Offerings Sold in Individual and Small Group Markets⁶

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. 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

⁶ 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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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.

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.

B. 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.

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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 recommends 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 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.

C. 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.

D. 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.⁷ The federal health reform law identifies three risk spreading or risk mitigation programs that will begin in 2014: risk adjustment; reinsurance; and a risk corridor. The first two will be administered at the state level, while the risk corridor will be a federal effort. The state risk adjustment program will apply to individual, small group and some large group products. The program will redistribute money from plans that incur lower than average risk to those with higher than average risk. The federal Health and Human Services Secretary will establish criteria and methods that will structure the state programs.

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.

⁷ HB 2009 Section 17(b)(G).

E. 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.

Building Oregon's Health Insurance Exchange

Appendix C: Legislative Concept and Brief on Legislative Recommendations for an Exchange

The attached legislative concept was intended to outline the minimum requirements of a Health Insurance Exchange as required by federal law and staff understanding at the time of drafting. The attached brief lists further recommendations of the OHPB for inclusion in Exchange legislation. Full details of the OHPB recommendations are included in this report on pages 13-22.

D R A F T

SUMMARY

Requires Oregon Health Authority to establish Oregon Health Insurance Exchange as public corporation to be governed by board of directors. Specifies functions and duties.

Declares emergency, effective on passage.

1

A BILL FOR AN ACT

2 Relating to Oregon Health Insurance Exchange; appropriating money; and
3 declaring an emergency.

4 **Be It Enacted by the People of the State of Oregon:**

5

6

OREGON HEALTH INSURANCE EXCHANGE

7

(Establishment)

8

9

SECTION 1. (1) By January 1, 2014, the Oregon Health Authority shall develop and establish the Oregon Health Insurance Exchange under sections 2 and 5 to 9 of this 2011 Act to ensure conformance with the requirements of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.

15

(2) The authority may apply for and accept federal grants, other federal funds and grants from nongovernment organizations for the purpose of developing and implementing the exchange. Moneys received by the authority under this subsection shall be deposited in or to the credit of the Oregon Health Insurance Exchange Fund established under section 11 of this 2011 Act and are continuously appro-

20

1 priated to the authority for developing and implementing the
2 exchange.

3 **SECTION 2.** (1) The Oregon Health Authority shall establish the
4 Oregon Health Insurance Exchange as a public corporation that shall
5 exercise and carry out all powers, rights and privileges that are ex-
6 pressly conferred upon it, are implied by law or are incident to such
7 powers. The exchange shall be a governmental entity performing gov-
8 ernmental functions and exercising governmental powers. The ex-
9 change shall be an independent public corporation with statewide
10 purposes and missions and without territorial boundaries. The ex-
11 change shall be a governmental entity but shall not be considered a
12 unit of local or municipal government or a state agency for purposes
13 of state statutes or constitutional provisions.

14 (2) ORS 279.835 to 279.855 and ORS chapters 240, 279A, 279B, 279C,
15 283, 291, 292 and 293 do not apply to the exchange.

16 (3) The exchange shall be governed by a board of directors consist-
17 ing of three ex officio members and six members who are appointed
18 by the Governor and subject to confirmation by the Senate in the
19 manner prescribed by ORS 171.562 and 171.565.

20 (4) The ex officio voting members of the board of directors are:

21 (a) The Director of the Oregon Health Authority;

22 (b) The Director of the Department of Consumer and Business
23 Services; and

24 (c) The chairperson of the Oregon Health Policy Board.

25 (5) The term of office of each member is four years. The Governor
26 may remove any member at any time for cause after notice and
27 hearing that shall be open to the public, but the Governor may not
28 remove more than three members within any four-year period except
29 for corrupt conduct in office. Before the expiration of the term of a
30 member, the Governor shall appoint a successor whose term begins
31 on January 1 next following. A member is eligible for no more than

1 two reappointments. If there is a vacancy for any cause, the Governor
2 shall make an appointment to become immediately effective for the
3 unexpired term.

4 (6) A member of the board of directors is entitled to compensation
5 and expenses as provided in ORS 292.495.

6 **SECTION 3.** Section 2 of this 2011 Act is amended to read:

7 (1) [*The Oregon Health Authority shall establish*] The Oregon Health In-
8 surance Exchange **is established** as a public corporation that shall exercise
9 and carry out all powers, rights and privileges that are expressly conferred
10 upon it, are implied by law or are incident to such powers. The exchange
11 shall be a governmental entity performing governmental functions and exer-
12 cising governmental powers. The exchange shall be an independent public
13 corporation with statewide purposes and missions and without territorial
14 boundaries. The exchange shall be a governmental entity but shall not be
15 considered a unit of local or municipal government or a state agency for
16 purposes of state statutes or constitutional provisions.

17 (2) ORS 279.835 to 279.855 and ORS chapters 240, 279A, 279B, 279C, 283,
18 291, 292 and 293 do not apply to the exchange.

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21 and subject to confirmation by the Senate in the manner prescribed by ORS
22 171.562 and 171.565.

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26 and

27 (c) The chairperson of the Oregon Health Policy Board.

28 (5) The term of office of each member is four years. The Governor may
29 remove any member at any time for cause after notice and hearing that shall
30 be open to the public, but the Governor may not remove more than three
31 members within any four-year period except for corrupt conduct in office.

1 Before the expiration of the term of a member, the Governor shall appoint
2 a successor whose term begins on January 1 next following. A member is
3 eligible for no more than two reappointments. If there is a vacancy for any
4 cause, the Governor shall make an appointment to become immediately ef-
5 fective for the unexpired term.

6 (6) A member of the board of directors is entitled to compensation and
7 expenses as provided in ORS 292.495.

8 **SECTION 4. Notwithstanding the term of office specified by section**
9 **2 of this 2011 Act, of the members first appointed to the Oregon Health**
10 **Insurance Exchange board of directors:**

11 (1) Two shall serve for terms ending December 31, 2013.

12 (2) Two shall serve for terms ending December 31, 2014.

13 (3) Two shall serve for terms ending on the earlier of four years
14 after appointment or December 31, 2015.

15

16 (Functions)

17

18 **SECTION 5. The functions of the Oregon Health Insurance Ex-**
19 **change are to:**

20 (1) Provide uniform information to consumers of health care on
21 costs, benefits, provider networks and other information to assist in-
22 dividuals and small businesses in making informed health care deci-
23 sions. At a minimum, the exchange shall provide:

24 (a) Information on:

25 (A) The average costs of licensing, regulatory fees and other pay-
26 ments required by the exchange;

27 (B) Exchange administrative costs; and

28 (C) Costs attributable to waste, fraud and abuse.

29 (b) An electronic calculator that allows individuals to determine the
30 cost of coverage after deducting any applicable tax credit or cost-
31 sharing reduction.

1 **(2) Screen, certify and recertify health plans as qualified to partic-**
2 **ipate in the exchange according to federal guidelines and to ensure**
3 **that qualified health plans provide meaningful coverage choices.**

4 **(3) Decertify plans to preclude further participation in the exchange**
5 **by plans that fail to meet federal standards.**

6 **(4) Ensure fair competition of carriers in and outside the exchange**
7 **by establishing:**

8 **(a) Standardized health benefit plan options; and**

9 **(b) An Internet-based clearinghouse and a toll-free telephone**
10 **hotline for information about plans in and outside the exchange, in-**
11 **cluding standardized comparisons of plan coverage and costs.**

12 **(5) Make qualified health plans available to individuals and em-**
13 **ployers and assist individual and group enrollment in qualified health**
14 **plans.**

15 **(6) Facilitate community-based assistance with enrollment in qual-**
16 **ified health plans, certify entities to be navigators as described in 42**
17 **U.S.C. 18031(i) and fund navigators to provide education and perform**
18 **eligibility determination and enrollment functions.**

19 **(7) Provide employers with the names of any of their employees who**
20 **end coverage under a qualified health plan during a plan year.**

21 **(8) Grade health plans in accordance with criteria established by the**
22 **Secretary of the United States Department of Health and Human Ser-**
23 **vices and distribute the information through the Internet-based**
24 **clearinghouse and toll-free telephone hotline.**

25 **(9) Certify that an individual meets the criteria for an exemption**
26 **from the individual responsibility requirement of section 5000A of the**
27 **Internal Revenue Code.**

28 **(10) Establish open, special and monthly enrollment periods for**
29 **Native American individuals.**

30 **(11) Provide information to individuals and employers regarding the**
31 **eligibility requirements for all publicly funded programs providing**

1 medical assistance and assist individuals in applying for the programs.

2 (12) Provide information to the federal government necessary for
3 enrollees to receive tax credits and reduced cost-sharing.

4 (13) Provide information to the federal government regarding:

5 (a) Individuals determined to be exempt from the individual re-
6 sponsibility requirement of section 5000A of the Internal Revenue
7 Code;

8 (b) Employees who have reported a change in employer; and

9 (c) Individuals who have ended coverage during a plan year.

10 (14) Enter into contracts to carry out the functions of and to pro-
11 vide the services offered by the exchange.

12

13 (Officers of Board of Directors; Quorum; Meetings)

14

15 SECTION 6. (1) The Oregon Health Insurance Exchange board of
16 directors shall select one of its members as chairperson and another
17 as vice chairperson, for such terms and with duties and powers nec-
18 essary for the performance of the functions of such offices as the
19 board determines.

20 (2) A majority of the members of the board of directors constitutes
21 a quorum for the transaction of business.

22 (3) The board of directors shall meet at least once every three
23 months at a place, day and hour determined by the board. The board
24 may also meet at other times and places specified by the call of the
25 chairperson or of a majority of the members of the board.

26

27 (Employees)

28

29 SECTION 7. (1) The Oregon Health Insurance Exchange board of
30 directors shall appoint an executive director to serve at the pleasure
31 of the board.

1 (2) The designation of the executive director must be by written
2 order, filed with the Secretary of State.

3 (3) The executive director shall appoint all subordinate officers and
4 employees of the Oregon Health Insurance Exchange, prescribe their
5 duties and fix their compensation.

6 (4) The executive director shall appoint and consult with:

7 (a) An advisory group consisting of no fewer than five consumers
8 of health care;

9 (b) An advisory group consisting of no fewer than five small busi-
10 ness owners; and

11 (c) An advisory group consisting of representatives of five carriers
12 participating in the Oregon Health Insurance Exchange.

13 (5) Members of the advisory groups are not entitled to compen-
14 sation, but at the discretion of the executive director may be reim-
15 bursed from funds available to the executive director for actual and
16 necessary travel and other expenses incurred by them in the per-
17 formance of their official duties.

18
19 (Authority to Adopt Rules and Collect Assessments)

20
21 SECTION 8. (1) In accordance with applicable provisions of ORS
22 chapter 183, the Oregon Health Insurance Exchange may:

23 (a) Adopt rules necessary for the administration of the exchange;
24 and

25 (b) Establish, impose and collect assessments on insurance carriers
26 as permitted or required by federal law for the operation of the ex-
27 change.

28 (2) All assessments received by or to the credit of the exchange
29 shall be deposited in the Oregon Health Insurance Exchange Fund es-
30 tablished under section 11 of this 2011 Act.

31

(Operation)

SECTION 9. (1) The following individuals and groups may purchase qualified health plans through the Oregon Health Insurance Exchange:

(a) Beginning January 1, 2014, individuals and employers with no more than 50 employees.

(b) Beginning January 1, 2016, employers with 51 to 100 employees.

(c) Groups meeting additional criteria established by the exchange for qualified purchasers.

(2)(a) Only individuals who purchase health plans through the exchange may be eligible to receive premium tax credits under section 36B of the Internal Revenue Code and reduced cost-sharing under 42 U.S.C. 18071.

(b) Only employers that purchase health plans through the exchange may be eligible to receive small employer health insurance credits under section 45R of the Internal Revenue Code.

(3) The exchange shall certify a health plan as qualified if:

(a) The plan provides coverage on terms established by the exchange by rule that, at a minimum, includes the essential health benefits established by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 18022; and

(b) The exchange determines that making the health plan available through the exchange is in the interests of individuals and employers in this state.

(4) The exchange is authorized to limit the number of qualified health plans available in each level of coverage described in 42 U.S.C. 18022(d) as bronze, silver, gold and platinum.

(5) The exchange shall establish a streamlined and seamless application and enrollment process for both the exchange and the state medical assistance program.

(6) The exchange, in collaboration with the department, shall coor-

1 **dinate federal and state risk mediation programs including:**

2 (a) **The reinsurance program established pursuant to 42 U.S.C.**
3 **18061;**

4 (b) **The federal program of risk corridors established pursuant to**
5 **42 U.S.C. 18062; and**

6 (c) **The state risk adjustment program administered pursuant to 42**
7 **U.S.C. 18063.**

8 (7) **The exchange shall define the role of insurance agents and bro-**
9 **kers within the operation of the exchange in accordance with federal**
10 **guidelines and policies adopted by the exchange by rule.**

11 (8) **The exchange shall ensure parity in premiums for plans sold**
12 **within and outside the exchange.**

13 (9) **The exchange is authorized to combine risk pools as permitted**
14 **by federal law to best serve the interests of individuals and small em-**
15 **ployers in this state.**

16 (10) **The exchange is authorized to enter into contracts for the**
17 **performance of duties and functions of the exchange including, but**
18 **not limited to, contracting with:**

19 (a) **Insurance carriers to offer coverage through the exchange; and**

20 (b) **Navigators certified by the exchange under section 5 of this 2011**
21 **Act.**

22 (11) **The exchange is authorized to apply for and accept federal**
23 **grants, other federal funds and grants from nongovernment organiza-**
24 **tions for the purpose of developing, implementing or administering the**
25 **exchange. Moneys received by the exchange under this subsection**
26 **shall be deposited in or to the credit of the Oregon Health Insurance**
27 **Exchange Fund established under section 11 of this 2011 Act and are**
28 **continuously appropriated to the exchange for developing, implement-**
29 **ing or administering the exchange.**

30 (12) **The exchange, in coordination with the Oregon Health Au-**
31 **thority and the Department of Consumer and Business Services, shall**

1 **plan and coordinate the phasing out of the Oregon Medical Insurance**
2 **Pool by January 1, 2014.**

3 **SECTION 10.** Section 9 of this 2011 Act is amended to read:

4 **Sec. 9.** (1) The following individuals and groups may purchase qualified
5 health plans through the Oregon Health Insurance Exchange:

6 [(a) *Beginning January 1, 2014, individuals and employers with no more*
7 *than 50 employees.*]

8 [(b)] (a) [*Beginning January 1, 2016, employers with 51 to*] **Individuals**
9 **and employers with no more than** 100 employees.

10 [(c)] (b) Groups meeting additional criteria established by the exchange
11 for qualified purchasers.

12 (2)(a) Only individuals who purchase health plans through the exchange
13 may be eligible to receive premium tax credits under section 36B of the
14 Internal Revenue Code and reduced cost-sharing under 42 U.S.C. 18071.

15 (b) Only employers that purchase health plans through the exchange may
16 be eligible to receive small employer health insurance credits under section
17 45R of the Internal Revenue Code.

18 (3) The exchange shall certify a health plan as qualified if:

19 (a) The plan provides coverage on terms established by the exchange by
20 rule that, at a minimum, includes the essential health benefits established
21 by the United States Secretary of Health and Human Services pursuant to
22 42 U.S.C. 18022; and

23 (b) The exchange determines that making the health plan available
24 through the exchange is in the interests of individuals and employers in this
25 state.

26 (4) The exchange is authorized to limit the number of qualified health
27 plans available in each level of coverage described in 42 U.S.C. 18022(d) as
28 bronze, silver, gold and platinum.

29 (5) The exchange shall establish a streamlined and seamless application
30 and enrollment process for both the exchange and the state medical assist-
31 ance program.

1 (6) The exchange, in collaboration with the department, shall coordinate
2 federal and state risk mediation programs including:

3 (a) The reinsurance program established pursuant to 42 U.S.C. 18061;

4 (b) The federal program of risk corridors established pursuant to 42 U.S.C.
5 18062; and

6 (c) The state risk adjustment program administered pursuant to 42 U.S.C.
7 18063.

8 (7) The exchange shall define the role of insurance agents and brokers
9 within the operation of the exchange in accordance with federal guidelines
10 and policies adopted by the exchange by rule.

11 (8) The exchange shall ensure parity in premiums for plans sold within
12 and outside the exchange.

13 (9) The exchange is authorized to combine risk pools as permitted by
14 federal law to best serve the interests of individuals and small employers in
15 this state.

16 (10) The exchange is authorized to enter into contracts for the perform-
17 ance of duties and functions of the exchange including, but not limited to,
18 contracting with:

19 (a) Insurance carriers to offer coverage through the exchange; and

20 (b) Navigators certified by the exchange under section 5 of this 2011 Act.

21 (11) The exchange is authorized to apply for and accept federal grants,
22 other federal funds and grants from nongovernment organizations for the
23 purpose of developing, implementing or administering the exchange. Moneys
24 received by the exchange under this subsection shall be deposited in or to
25 the credit of the Oregon Health Insurance Exchange Fund established under
26 section 11 of this 2011 Act and are continuously appropriated to the ex-
27 change for developing, implementing or administering the exchange.

28 *[(12) The exchange, in coordination with the Oregon Health Authority and*
29 *the Department of Consumer and Business Services, shall plan and coordinate*
30 *the phasing out of the Oregon Medical Insurance Pool by January 1, 2014.]*

31

1 **OREGON HEALTH INSURANCE EXCHANGE FUND**

2

3 **SECTION 11.** **The Oregon Health Insurance Exchange Fund is es-**
 4 **tablished in the State Treasury, separate and distinct from the General**
 5 **Fund. The Oregon Health Insurance Exchange Fund consists of mon-**
 6 **eys received by the Oregon Health Authority as grants under section**
 7 **1 of this 2011 Act, moneys received by the Oregon Health Insurance**
 8 **Exchange through the imposition of assessments under section 8 of**
 9 **this 2011 Act and moneys received as gifts or grants under section 9**
 10 **(11) of this 2011 Act. Moneys in the fund are continuously appropriated**
 11 **to the Oregon Health Authority for carrying out the purposes of**
 12 **sections 1, 2 and 5 to 9 of this 2011 Act.**

13 **SECTION 12.** Section 11 of this 2011 Act is amended to read:

14 **Sec. 11.** The Oregon Health Insurance Exchange Fund is established in
 15 the State Treasury, separate and distinct from the General Fund. The Oregon
 16 Health Insurance Exchange Fund consists of [*moneys received by the Oregon*
 17 *Health Authority as grants under section 1 of this 2011 Act,*] moneys received
 18 by the Oregon Health Insurance Exchange through the imposition of assess-
 19 ments under section 8 of this 2011 Act and moneys received as gifts or grants
 20 under section 9 (11) of this 2011 Act. Moneys in the fund are continuously
 21 appropriated to the Oregon Health [*Authority*] **Insurance Exchange** for
 22 carrying out the purposes of sections [*1,*] 2 and 5 to 9 of this 2011 Act.

23 **SECTION 13.** **There is appropriated to the Oregon Health Authority,**
 24 **for the biennium beginning July 1, 2011, out of the General Fund, the**
 25 **amount of \$_____ for the purpose of developing and implementing the**
 26 **Oregon Health Insurance Exchange in accordance with sections 1, 2**
 27 **and 5 to 9 of this 2011 Act.**

28

29 **DELAYED OPERATIVE DATES AND REPEAL**

30

31 **SECTION 14.** (1) The amendments to sections 2 and 11 of this 2011

1 Act by sections 3 and 12 of this 2011 Act become operative January 2,
2 2014.

3 (2) Section 1 of this 2011 Act is repealed January 2, 2014.

4 (3) The amendments to section 9 of this 2011 Act by section 10 of
5 this 2011 Act become operative January 1, 2016.

6

7

CAPTIONS

8

9 SECTION 15. The unit captions used in this 2011 Act are provided
10 only for the convenience of the reader and do not become part of the
11 statutory law of this state or express any legislative intent in the
12 enactment of this 2011 Act.

13

14

EMERGENCY CLAUSE

15

16 SECTION 16. This 2011 Act being necessary for the immediate
17 preservation of the public peace, health and safety, an emergency is
18 declared to exist, and this 2011 Act takes effect on its passage.

19

Health Insurance Exchange Report Appendix C: Legislative Concept and Brief on Legislative Recommendations for an Exchange

Legislative Recommendations for Oregon's Health Insurance Exchange

The Oregon Health Insurance Exchange:

A health insurance exchange is a central marketplace for health insurance:

- Provides one-stop shopping for individuals and small businesses to compare rates, benefits and quality among plans
 - Meaningful choice of health plans and providers
 - Apples-to-apples comparisons
 - Easy payment processing
- Administers the new federal health insurance tax credits
- Offers an improved, modern access to Medicaid
- Makes it easier to enroll in health insurance
- Provides excellent customer service
- Offers clear value for the premium dollar

Oregon's Exchange Will Provide Value:

- For consumers: access, choice, service
- For employers: defined contribution, administrative simplicity, convenience
- For participating health plans: level playing field, administrative assistance
- For the market as a whole: transparent, comprehensive information, education & outreach

Statutory Authority to Meet Federal Requirements

- Provide information to consumers on plans, eligibility, etc (toll-free hotline, web site, electronic calculator, standardized benefits info)
- Screen/certify/recertify health plans
- Grade health plans on price and quality
- Decertify plans that fail to meet standards
- Ensure fair competition of carriers in and out of Exchange
- Enter into contracts to carry out functions and provide services
- Facilitate community-based assistance (Navigator program)
- Conduct open enrollment periods
- Certify exemptions from the individual responsibility requirement
- Apply for and accept grants and other funds
- Consult with stakeholders, including Tribes
- Collect and present enrollee satisfaction survey results
- Publish data on Exchange administrative costs
- Provide required information to federal government

Policy Board recommendations:

- Statutory charter that includes:

Health Insurance Exchange Report Appendix C: Legislative Concept and Brief on Legislative Recommendations for an Exchange

- Strong consumer-oriented mission statement
- Must comply with ORS requirements for accountability and transparency (public meetings, public records, public comment)
- Exchange run by a public corporation (government entity)
- Mechanisms to ensure accountability:
 - Nine member board appointed by Governor, confirmed by Senate
 - Voting *ex officio* members: Oregon Health Authority Director, Department of Consumer and Business Services Director, Oregon Health Policy Board Chair
 - Board elects officers
 - Strong conflict of interest language
 - Consumer advisory groups
 - Consumer surveys
 - Exchange subject to ORS 243 Public Employee Rights and Benefits
 - Requirement and authority to collaborate with OHA, DCBS, Employment, Revenue