Oregon Health Fund Board

Finance Committee Recommendations to the Oregon Health Fund Board

Part II: Exchange Work Group Recommendations on Individual Market Reform and Exchange Functions, Participants and Administration

June 2008

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EXCHANGE WORK GROUP OF THE FINANCE COMMITTEE
RECOMMENDATIONS TO THE HEALTH FUND BOARD

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EXECUTIVE SUMMARY

INTRODUCTION

The 2007 Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007), which established a seven-member Oregon Health Fund Board tasked with developing a comprehensive plan to: ensure access to health care for all Oregonians, contain health care costs, and improve health care quality. The Board gave the Finance Committee's Exchange Work Group the task of developing recommendations for individual (non-group) market changes within a comprehensive reform plan. The Work Group was asked to recommend the role a health insurance exchange would play in such an environment. The thirteen member Work Group met twelve times between November 2007 and May 2008.

COMMITTEE PROCESS

The Work Group was guided by the Board's assumption that reform would include an individual insurance requirement and state premium contributions for lower-income Oregonians. To support these assumptions, the group agreed that the following conditions would also need to exist:

- A guaranteed issue and guaranteed renewal individual market;
- An affordable, accessible and consumer-valued essential services benefit package; and
- Carriers that compete based on the efficiency of their administration, on delivery system and network adequacy, and on other quality and service differences, not on a carrier's ability to enroll lower risk members.

The Work Group identified the following goals for a reformed individual market. Coverage must be affordable for both healthy and high-risk Oregonians, and rates must be stable over time. Entry into coverage must be easy, with information on all options made available. Market conditions should encourage insurance carrier participation by managing risk selection and minimizing carriers' administrative costs. Risk adjustment should be used to mitigate the effect of adverse risk on carriers. A sustainable financing approach should be utilized for high-risk populations in order to minimize the impact on rates for the currently insured.

Within this context, the Work Group identified the problems with the current health insurance markets, recommended reforms to the individual market, proposed functions and participant populations for an exchange, and identified possible administrative and financing options for an exchange. Work Group members expressed a range of views on these topics. While consensus was not reached on all topics, the group took great efforts to identify points of agreement and express the implications of the various options.

RECOMMENDATIONS

Individual Market Reforms:

Ensure affordable access to insurance in the individual market, establish a single individual market risk pool, and limit market disruption for current enrollees. The majority of the Work Group recommended the state discontinue pre-enrollment medical screening and create a single, guaranteed issue market for individual insurance coverage. This would mean that individuals would no longer be required to fill out a medical screening form and could not be denied coverage based on health status. The existing underwritten market would be combined with the portability market and the state high-risk pool, the Oregon Medical Insurance Pool (OMIP). Other members preferred maintaining a modified version of the current system. All members encouraged changes that would ensure fair and equitable movement into insurance, and incorporate new populations and their costs in a way that limits disruption to the currently insured population.

If the market becomes guaranteed issue, many members suggested that during a short transition period, the assessment that now partially funds OMIP be used to moderate the rate impact of combining three pools into one unified individual market. After one to two years, the assessment would be discontinued. If an individual mandate is not implemented or enforced, the group would not recommend guaranteed issue, and would instead suggest the underwritten market be maintained.

Manage risk in the reformed individual market with a strong risk adjustment mechanism. To support a guaranteed issue individual market, the Work Group recommends using a strong risk adjustment method to shift revenue between insurance carriers based on the risk of each carrier's enrolled population. In any scenario, some carriers will have higher cost enrollees. Risk adjustment would help ensure carriers are paid for enrolled populations and compete on medical management, quality and price, not risk selection. The Work Group did not recommend a specific methodology, but notes that the methodology adopted should be rigorous and be applied and routinely reviewed by qualified, independent personnel and outside experts to ensure its ongoing value and efficacy.

Maintain a strong individual market by making rating rules consistent and transparent. The majority preferred a natural rate band, in which the oldest enrollees pay approximately 5.5 times the rate paid by the youngest. However, several members believe this is too broad a spread. The group supports some age rating, basing the medical component of rates on all of a carrier's enrollees, and increased rate transparency. They would allow rate adjustments for geography and "healthy behaviors," but not for gender and health status. The group would continue the Department of Consumer and Business Services' (DCBS) role in reviewing carrier rates, including monitoring for risk selection issues, and the majority would not initially change small group rating rules. Small groups have different rating rules than individuals and are pooled separately from individuals. M Work Group members were concerned about how to address these differences. As there was disagreement on several issues, the majority of the group supports a thorough evaluation of rating bands and the small group market, which could lead to changes in the bands and small group rules after other individual market changes are implemented.

Use the essential services benefit definition to establish product foundation and tiers. The Work Group recommends that all individual market carriers offer the essential services benefit. Each carrier may offer other "buy up" plans within benefit tiers defined by the Board. The group recommends insurance products continue to be reviewed by DCBS, including a carrier demonstration that products offered meet or exceed the essential services benefit.

Maintain current treatment of self-employed sole employees. The Work Group felt that in order to avoid adverse selection issues, self-employed individuals with no other employees should be allowed to continue buying individual market insurance, but not group market coverage.

Section 125 Premium Only Plans:

All employers should be required to establish Section 125 Premium Only Plans for their employees. This would apply to employers whether or not they offer health benefits. Employers that pay 100% of premiums for all employees would be exempt from this requirement. The Work Group agreed that this should be required because use by employees is voluntary and can significantly reduce the cost of individual insurance purchase by letting individuals use pre-tax dollars for premium purchase.[1]

Exchange Functions:

While the group's charge was to develop the role of an exchange, some members questioned the need for an exchange, arguing that the Family Health Insurance Assistance Program and individual agents and brokers already provide many of the functions of an exchange. Others argued a well organized exchange could have a greater impact on the efficiency of the non-group market.

The exchange should operate as a strong market organizer by contracting with carriers and establishing performance benchmarks across carriers. While the Work Group did not come to consensus on the level at which an exchange should function, most members of the group were in general agreement that an exchange should have a strong role in moving the market by standardizing benefits offered by carriers and establishing performance benchmarks across carriers. All carriers that meet the benchmark standards could offer coverage through the exchange.

Exchange Participant Populations:

Individuals who use state premium contributions or access tax credits must get coverage through the exchange. Higher income workers not offered or eligible for employer-sponsored coverage can enter the exchange and use Section 125 Premium Only Plans to reduce premium costs. A majority of the Work Group wanted to provide choice for purchasers not utilizing direct or indirect state assistance by allowing other individual market purchasers to use the exchange without requiring them to do so. Some members argued the exchange would be stronger and less complex if all individual purchasers were required to enroll through the exchange; the majority wanted the exchange to prove itself through efficiency and by offering value to consumers. The decision about whether to offer individuals a choice of the exchange or direct market should be reevaluated after some period. The group agreed that voluntary enrollment for the unsubsidized

[1] Federal law limits the use of Section 125 Plans for individual insurance premiums to guaranteed issue markets.

group should be tied to the implementation of the individual market reforms laid out in the first section of the report.

Exchange Administration and Financing:

The exchange's administrative structure should facilitate accountability, transparency and responsiveness, and allow flexibility and market responsiveness. The Work Group believes an exchange should be strongly responsive to the public. Although no recommendation was made on administrative structure, the group leaned toward a public entity that balances public accountability and responsiveness.

The exchange should be relatively self-supporting. The Work Group supported the concept of a fee to support the exchange's administration of subsidies, with other sources of funding for customer service, marketing the exchange and other functions. The group did not reach a consensus on the actual sources to be used or how much funding should come from which source.

Employer Groups and the Exchange:

Do not initially offer small employer groups coverage in the exchange. Small employer groups could benefit from access to an exchange, and some Work Group members support immediately merging the small group and individual markets. However, many in the Work Group thought the policy and administrative goals of doing so are not yet clear enough to fully consider how to include small groups. Issues that would need to be addressed include: the role of the small group pool; the impact of combining pools; the different rating rules between the individual and small group markets; and how to manage adverse selection in a voluntary exchange. Work Group members hoped that once the exchange was established, employer groups would have the opportunity to participate in the future. The Work Group recognizes that in the current scenario, employers that are currently providing insurance to employees may decide to drop group coverage in order to provide their employees with access to the exchange.

INTRODUCTION

Charge to the Work Group

The charter of the Oregon Health Fund Board's Finance Committee calls for the establishment of a Work Group to develop recommendations regarding changes to the individual (non-group) market within a comprehensive reform plan. The charter specifies that the recommendations should include the role a health insurance exchange would play in such an environment.[2] The Work Group tackled these issues and also discussed issues related to the small group market.

Exchange Work Group Process

With that charge, the Exchange Work Group was established and began holding public meetings in November 2007. The thirteen members of the Work Group, which met twelve times between November 2007 and May 2008, represented a variety of perspectives, including health insurers, insurance agents, unions, public interest advocates, and employers.[3]

The Work Group met bi-monthly through April 2008, working together to develop the following set of recommendations for the Finance Committee's review. The group began by identifying a long list of issues that would need attention in order to develop recommendations about reforms to the individual market. The group also listed the topics to be addressed in discussions about an exchange's recommended structure, function and participant populations.

The group then began to tackle the list, starting with a discussion of the problems of the existing individual market, as well as the goals of a reformed market and the opportunities presented. Based on the assumptions from the Board and the goals identified by the Work Group, the group developed recommendations for reforming an individual market. While not all members agreed, most of the group supported moving toward a guaranteed issue individual market, as long as an individual insurance requirement was established in the state.

The group then turned to the development of an exchange, discussing the roles an exchange can play, the populations that could use it, and possible administration and financing options for an exchange. Work Group members expressed a range of views on these topics. While consensus was not reached on all topics, the group took great efforts to identify points of agreement and express the implications of the various options. A majority of the Work Group agreed that an exchange should contract with plans and set performance standards in order to improve access to quality, affordable insurance.

Several members of the Work Group felt strongly that changes in the individual market should be paired with small group market reforms. Although this topic was outside of the original scope of the group's work, it was considered important enough that considerable time was spent in discussion of the issue. The group was not able to fully resolve whether and how to make

[2] For the Charter see Part I of the Finance Committee report (Financing Sources for Reform), Appendix A.
[3] For a full listing of the Work Group membership, please see Appendix A.

changes in the small group market, but identified a number of areas for future discussion and analysis.

In March, the Work Group Chair presented recommendations to the Finance Committee on market reform proposals. The exchange recommendations were presented in May. Both presentations included significant discussion and feedback from the Finance Committee. While a few recommendations were modified based on Finance Committee input, for the most part the recommendations were accepted by the Finance Committee. Once approved by the Committee, these recommendations were finalized for the Board.

REVIEW OF OREGON'S INSURANCE MARKET AND PROBLEM IDENTIFICATION

Oregon's Current Individual and Small Group Insurance Markets

Before considering any changes to the individual insurance market, the Work Group first examined the current state of that market as well as the small group market in Oregon.

In 2006, Oregon's population was roughly 3.7 million. Roughly 200,000 people (6%) got health insurance through the individual market.[4] Compared to other states, Oregon's individual market is relatively large and has high insurance carrier participation. This is partly due to the existence of a high-risk pool, the Oregon Medical Insurance Pool (OMIP), which enrolls over 17,000 Oregonians considered uninsurable in the underwritten individual market. With this mechanism in place, healthy individuals in Oregon pay lower premiums than they would in a single pooled market. Current problems in the individual market include an increasing medical screening rejection rate and an OMIP assessment that has increased substantially.

An additional 19,000 people are now in Oregon's portability market, which is designed to provide comparably priced health insurance coverage to people who lose employment-related coverage. For employees who leave fully-insured employer coverage, coverage is provided by the insurance carriers. OMIP provides coverage for individuals leaving self-insured employer plans.

Approximately 264,000 people are enrolled in coverage through Oregon's small group market, defined as groups of 2 to 50 employees. Approximately 576,000 Oregonians (15.6% of the state population) lack insurance. Affordability is one reason for this high rate of uninsurance. Only 25% of the uninsured have incomes above 200% of the Federal Poverty Level (FPL).[5]

Individual and Small Group Insurance Market Regulations

Applicants for coverage in Oregon's individual insurance undergo medical screening, and insurers may turn down applicants based on their medical histories. This process is called medical underwriting.[6] According to the Department of Consumer and Business Services (DCBS), about 27% of applicants are declined. Individuals screened out of the individual insurance market may purchase insurance through Oregon's high-risk pool, OMIP. Once someone is enrolled in an individual coverage product the applicant has guaranteed renewal, meaning coverage may not be dropped due to medical diagnoses or use of services.[7]

Oregon allows rates in the individual market to be adjusted for the subscriber's age and for geography. The medical claims history of an enrolled individual cannot be considered. A 50-

[4] This does not include the more than 17,000 people enrolled in Oregon's high-risk pool (the Oregon Medical Insurance Pool) and 19,000 enrolled in portability coverage.
[5] The 2008 federal poverty level is $17,600 for a family of three.
[6] The alternative to this system is one in which applicants are guaranteed coverage ("guaranteed issue").
[7] The requirement that. once an individual is covered, the insurer can not discontinue coverage due to the individual's health status or health care use is referred to as "guaranteed renewability"

year-old would pay more than a 25-year-old due to the higher average health care costs for the older group. A 25-year-old with high medical claims will pay the same as a healthy 25-year-old.

The premiums for each age range represent the average projected cost of providing health care to people within that age band. While any given individual may have higher or lower health care costs, on average older enrollees cost more than younger ones. The individual insurance market does not have a regulated rate band. Most insurers use a "natural" rate band, in which premiums for the highest cost age group are not more than 5.6 times the premiums charged the lowest cost age group.

The individual market differs from the small group market, which in 2007 began to phase in a 3:1 rate band based on age, retention and participation in wellness programs. Small group coverage does not offer different rates to each employee based on age. All employees covered by a small employer get the same rate, based on the group as a whole. Health and claims status can affect rates by up to 5% based on expected claims experience of a small employer. The 3:1 band means that the premium charged to the highest-cost group cannot be more than three times that charged for the lowest-cost group. As in the individual market, premiums paid by small groups are not based on the group's actual claims costs but on the average cost for groups with similar characteristics.

Portability coverage, which is available to Oregonians who leave group coverage and meet certain eligibility standards, is governed by rules similar to those in the small group market. By federal law, all states offer portability coverage; Oregon law requires group health insurance carriers to offer portability coverage to people leaving employer sponsored group coverage. OMIP provides portability coverage for people leaving group coverage provided by a self-insured plan. Rates for portability coverage are based on group coverage, but issued on an individual basis.

Problem Identification

As discussed above, the current individual market in Oregon is relatively healthy compared to other states. Many insurers participate in the market, the size of the market is relatively large, and participants can choose from a wide range of relatively affordable products. OMIP premiums are capped at 125% of underwritten individual market premiums. To ensure this, OMIP expenditures are subsidized through an assessment on licensed Oregon health insurers, re-insurers, and stop-loss carriers. While this approach offers a form of guaranteed issue, premiums in the high-risk pool are high.

The current system has helped maintain a relatively stable underwritten individual market, but it has also created some problems. Even with its cap on premium levels, some people find OMIP premiums unaffordable. Some believe that the process can cause delayed access to coverage and medical care. In addition, medical screening builds in administrative costs for insurers. Finally, some consumers find it difficult to obtain clear and comparable information on all health plan options available to them.

The OMIP assessment of approximately $3.50 per member per month[8] is opposed by many stop-loss carriers, who consider it an unfair application of the law to charge all insurers and stop-loss carriers the same per member per month fee regardless of premium level. For stop-loss carriers, the OMIP assessment is a significant portion of their premium, compared to the premium for a fully insured plan.

The current system also has weaknesses for small group insurance purchasers. Employees of small groups usually do not have a choice of carriers and limited portability. When employees move from one employer to another, they often must switch health plans.

[8] The premium was $3.50 per member per month between July 2007 and June 2008.

WORK GROUP GUIDING ASSUMPTIONS AND EARLY WORK

After reviewing the current state of the individual market in Oregon, the Exchange Work Group began working on its recommendations for reforming the individual market. To do so, the members first reviewed the Board's assumptions regarding what a comprehensive reform plan will look like. Two of the assumptions outlined in the Board's "Design Principles and Assumptions" document apply specifically to the work of this group:

- Individuals will be required to have health insurance coverage.
- A state premium contribution will be available for low-income people. Premium assistance paired with a mandate allows lower-income individuals to acquire and retain coverage.

Based on these assumptions, the Work Group developed several additional market requirements:

- With an individual insurance requirement in place, the individual market should be guaranteed issue and guaranteed renewal. Individuals may not be denied coverage because of pre-existing conditions.

- Oregon must have an essential services benefit package that is affordable, accessible and consumer-valued. The group agreed that the Department of Consumer and Business Services (DCBS) needs to continue its review of the medical loss ratios and administrative costs that make up insurance rates to ensure that rates, risk-based capital requirements and margins are sufficient but not excessive.

- Carriers should compete based on the efficiency of their administration, on delivery system and network adequacy, on premium, and on other quality and service differences, rather than on a given carrier's ability to enroll lower risk members.

The group agreed that market reforms are needed in order to implement an individual insurance requirement, whether or not reforms include the establishment of an exchange. A few members of the Work Group argued that an exchange is not necessary in Oregon, as some potential exchange functions are currently performed by existing state agencies and private-sector individuals or organizations. The majority view of the group was that an exchange could add value in a reformed market, and the group agreed to consider what an exchange could do and for whom. Before assessing the role of an exchange in Oregon, the Work Group tackled the details of market reforms for the state's individual market.

GOALS OF A REFORMED INDIVIDUAL INSURANCE MARKET

Using the assumptions from the Board and those developed by the group as a guide, the Exchange Work Group created a list of potential goals for a reformed individual market.

Affordability
A market that utilizes medical screening and a high-risk pool is affordable to many who meet medical screening criteria, but is less affordable for many, including those deemed uninsurable. Rates must be affordable to both healthy and high-risk individuals. Subsidies will be needed for lower-income individuals.

Stable Rates
Rates must be stable over time, increasing at a predictable rate.

Minimize Impact on the Currently Insured
The use of medical screening and a high-risk pool minimizes the cost impact on people currently insured in the underwritten individual market. Moving to guaranteed issue will increase rates for the currently insured, as more expensive individuals (previous medically screened out) are included in the pool. To avoid rate shock, this process will need to be managed. In addition, reforms proposed by the Delivery System Committee are intended to help control costs across the entire health insurance market.

Easy Access to Coverage for Consumers
In the current market, some consumers face difficulties getting clear and comparable information on all health plan options. In a reformed market, useful information on all options must be available.

Participation by Numerous Insurance Carriers
The current market benefits from strong insurance carrier participation. To ensure continued carrier participation if the market becomes guaranteed issue, the state must enforce the individual requirement for coverage and establish market conditions that manage risk selection and create a level playing field. A guaranteed issue market would utilize risk adjustment to mitigate the effect of adverse risk events on carriers.

Minimize Insurance Carriers' Administrative Costs
A reformed market should minimize carriers' administrative expense. For example, eliminating medical underwriting will reduce carrier costs for pre-enrollment activities.

Sustainable Financing for High-Risk Populations
While the current financing for the high-risk population through OMIP is very broad-based, it is not a sustainable long-term funding source and has a large impact on insurers and stop-loss carriers. The individual market should have a sustainable financing approach for this high-risk population.

MARKET REFORM RECOMMENDATIONS

The Work Group recommends moving to a full guaranteed issue market with coverage for pre-existing conditions if there is an enforceable individual insurance requirement and state premium contributions for lower-income Oregonians. The group saw the two pieces as linked; a requirement that individuals purchase insurance should be paired with improved access to coverage through guaranteed issue, and guaranteed issue should not be implemented without a coverage mandate.

Several members expressed support for a six- to twelve-month waiting period for pre-existing conditions. A waiting period would be intended to deter people who might otherwise move to Oregon for health insurance coverage. The group as a whole agreed that no permanent pre-existing condition exclusions should be allowed.

In addition, the group recommends a number of changes in the market that would support a sustainable and viable market into the future. These recommendations are based on the assumptions that all Oregonians will be required to enroll in coverage, that state premium contributions will be available to help low-income individuals afford coverage, and that the individual coverage requirement will be enforced. If any of these assumptions are not met, the group would instead recommend modifications to the current underwritten market (including the high-risk pool).

Recommendation 1: Ensure Affordable Access to Insurance in the Individual Market, Establish a Single Individual Market Risk Pool, and Limit Market Disruption for Current Enrollees

Once a mandate is put in place, people must be able to easily get affordable, meaningful insurance. To facilitate this, the Work Group recommends the discontinuation of pre-enrollment medical screening tools.

As the guaranteed issue market will provide access to coverage without medical underwriting, the group recommends combining the three existing pools (the underwritten market, the portability market and the high-risk pool, OMIP) into one risk pool.

Combining the pools will significantly change the rates for the three market segments. While the market consolidation will increase rates for the currently underwritten market, the change helps other enrollees. In addition, it could cause some current individual market purchasers to seek coverage through employers where such coverage is available. To assess the impact that market consolidation could have on individual market rates, an actuary modeled individual market rates under a merged individual insurance market.

For the 200,000 people in the current underwritten market, the rates will increase 14-21%. The estimated 19,000 current portability and 17,000 OMIP enrollees would see 13% and 29% rate decreases, respectively. For more information on the data sources and results of this analysis, please see Appendix B. Merging the market without offering support during the transition could lead to a 21% rate increase for the underwritten market. The impact would be reduced to 14% if

the OMIP assessment was used to subsidize all individual premiums during a one to two year transition period.

The Work Group recommends that during a one to two year transition period, the assessment that currently funds OMIP be used to moderate the rate impact of OMIP participants joining the unified individual market. After the transition period, discontinue the OMIP assessment. In addition, some Work Group members suggested exploring ways to target the OMIP funds during the transition in order to subsidize lower-income participants.

The group agreed that ensuring that all Oregonians enroll and remain in coverage will reduce costs for the insured to some extent, as universal or near universal enrollment will greatly reduce the cost shift associated with care for the uninsured. To encourage currently insured people to retain their coverage, the penalty for non-coverage must be substantial.[9]

The Exchange Work Group strongly asserts that market reforms must be implemented in a way that ensures both fair and equitable movement into insurance, and that costs for new populations are absorbed in a way that does not hurt the success of an individual pool.

The group recognizes that many current enrollees will see some initial increase in rates and recommends steps be taken to mitigate this increase. This may be impacted by the structure of the essential benefits package. In particular, the group suggests further study into ways to reduce the impact of changes, especially for lower-income people. One way to address the needs of lower-income Oregonians is to make the state premium assistance reach as many people as possible. Reforms proposed by the Delivery System Committee also will hopefully help reduce the upward trend in health insurance costs.

The Work Group recommends that low and moderate income individuals with access to employer sponsored coverage be given access to the state premium contributions that will be made available to those without access to employer coverage. The Work Group believes that this is the most equitable course, but recognizes that the cost associated with this decision will be significant. If lower-income people with access to employer sponsored insurance will have access to state premium contributions, more work must be done to develop ways to ensure people get the assistance they need without reducing employers' willingness to continue contributing toward employees' health insurance premiums through group coverage. If such individuals are not given access to state contributions, employers could choose to drop group coverage in order to ensure that their employees had a way to access state assistance.

Recommendation 2: Manage Risk in the Reformed Individual Market through a Strong Risk Adjustment Mechanism

The majority of the Work Group agreed that to support an individual market based on guaranteed issue, the reformed market should include strong risk adjustment on the medical component of the premium. This would distribute revenue between insurance carriers based on the risk of each carrier's enrolled population. Such a mechanism will provide additional revenue to carriers that enroll high-risk individuals, while those with lower risk individuals receive less. Members

[9] See Recommendation 7, on the enforcement of an individual insurance requirement, for more on this issue.

argued that risk adjustment should be based on the medical component of the rates, so that carriers do not have an incentive to increase administrative costs relative to the total premium. Basing the adjustment on risk of the carrier's population recognizes that a carrier may enroll higher cost people and should have an incentive to care for them, rather than to encourage them to find a different carrier.

While the majority of the group agreed that a risk adjuster was needed, at least one member was not convinced. This member argued that without risk adjustment, carriers offering primarily the essential benefit coverage with fewer buy-ups would end up with a healthier segment of the population, while those offering richer packages would be likely attract higher risk enrollees. This would place price pressure on more robust coverage and provide an economic incentive for individuals to better manage their care and be better health care consumers. This member was concerned that implementation of risk adjustment would penalize healthier populations by providing a disincentive to control use, causing them to subsidize higher risk populations and reducing economic incentives for better health management.

At this time, the Work Group prefers a prospective approach to risk adjustment of the medical component of premiums, but does not have a recommendation for the form the risk adjustment should take. Details including whether the methodology should be prospective or retrospective are likely to be influenced by the structure of a health insurance exchange, and are discussed in more detail later in this report.

In considering the use of a risk adjuster in the individual market, the Work Group agreed that an insurance carrier's experience for all its enrollees should be used to develop the medical cost component of the carrier's rates. This is the number to which the risk adjuster would be applied. Rates in the individual market pool should reflect the risk of all enrollees, whether they purchase insurance inside or outside of a health insurance exchange. Only the medical component of rates should be used for risk adjustment.

The state of the art in risk adjustment continues to evolve. In order to ensure that the risk adjustment mechanism chosen provides protections to all carriers and the state, the Work Group recommends that the risk adjustment methodology established is routinely reviewed and modified to ensure its ongoing value and efficacy. The risk adjustment mechanism must be applied and assessed by qualified and independent personnel and outside experts as needed.

In a "dual" market, one in which many individual purchasers have the option of buying coverage through the exchange or in the direct market, the exchange itself can not administer the risk adjuster. This task could be given to DCBS, or placed in another existing or new state agency. In a market in which the risk adjuster affects all individual market players, the process must be administered and overseen by a trusted and impartial entity.

Recommendation 3: Make Rating Rules Consistent and Transparent

Even with strong risk adjustment, the market needs the support of clear and consistently applied rating rules. The Work Group discussed a variety of ways the rating rules can help support risk adjustment to maintain a strong individual market. There was some disagreement within the

group about the extent to which carrier flexibility should be limited in the name of consistency, with several members expressing concern that too much regulation was paramount to price controls that would discourage carrier innovation. The group agreed that additional transparency would be beneficial. The other items discussed below do not represent large change from the current system, but rather reinforce the current system with some changes where the group felt improvements could be made.

- **Increase Rate Transparency.** To better understand insurance rates, consumers should have greater ability to know what goes into the medical and administrative cost components of rates. Statute or regulation should be used to tighten rules regarding transparency and ensure consumer access to this information.

- **Individual Market Rates Should Continue to be Age Rated within Natural Rate Bands.** It is well established that for adults, need for services is correlated with age. Age should continue to be an allowed rating factor, and all carriers should use five-year age bands for rating enrollees over age 19. All enrollees age 19 and under will be covered by a single rate band. This band must comply with the natural rate band that is used to set prices.

- **Use a Natural Rate Band.** The Work Group also discussed how much difference there should be between the lowest and highest rates in the individual market. A smaller range reduces the difference paid between younger and older enrollees, while a larger spread lowers cost for young enrollees at the expense of older participants. To reduce disruption, the Work Group suggests continuing with the current natural rate band based on the actual experience of the overall individual market, currently around 5.6:1. The group recommends a reassessment of this decision after some period to see if the rate band should be collapsed further.

- **Do Not Allow Gender or Health Factors in Rate Setting.** The Work Group recommends prohibiting the use of gender or health factors in rate setting. Using gender would cause rates to be uniformly higher for women than for men. Allowing health to be a criterion would cause sick persons to pay significantly more than healthy ones. The group agreed that some cross-subsidization from the healthy to the sick is beneficial, and that allowing health status to be used would doubly penalize older enrollees. Some Work Group members felt the rating bands should be collapsed more.

- **Allow Geography as a Rate Setting Factor.** While many carriers in Oregon do not utilize geography-based rating, some do when costs in one region differ significantly from other parts of the state. The Work Group recommends that geography-based rating continue to be allowed, and DCBS oversight of this rating factor should be maintained. Carriers would continue to provide information to show that geographic differences in rates are borne out in the population and medical cost differences. The impact of this policy should be evaluated over time, and adjustments should be made to policy if needed.

- **Allow but Do Not Require "Healthy Behaviors" Rate Adjustments.** It is popular to discuss carrier and government efforts to encourage healthy behaviors, such as smoking cessation classes and wellness classes. Due to the cost and difficulty of administering such

rate adjustments, the Work Group recommends allowing but not requiring carriers to utilize premium discounts for "healthy behaviors." In addition, the market could work to encourage healthy behaviors through means other than rating.

- **Continue DCBS Review.** The Work Group urged that the Department of Consumer and Business Services' role in reviewing carrier rates should continue. As it does now, DCBS would conduct a robust review of rates to determine that they are sufficient but not excessive. Some members stressed that the review should include an evaluation of carrier investment income and surplus levels above the minimum required.

  The group noted that while DCBS should continue to review and approve premiums and monitor plans for risk selection issues, the Department will take on additional tasks, such as administering the risk adjuster. In addition, members noted that if a voluntary exchange is established, DCBS responsibilities will increase. Some individual market enrollees will seek insurance through the exchange, while others will continue to use the direct market. DCBS must be able to review all insurance carrier filings, whether their products are sold through the exchange or the direct market.

- **Do Not Initially Change Small Group Rating Rules.** The Work Group was divided regarding whether to alter rating rules in the small group market. This market recently underwent changes to its rating structure when it merged with the medium group market, and the changes have caused some disruption in the small group market. While some members felt that the individual and small group markets should be merged immediately, others felt that the additional disruption should be either avoided or postponed.

  While the Work Group did not reach consensus on whether or how small group rating rules should immediately be altered, a majority of the group agreed that the small group market should initially be kept as it is today. Due to the complexity of the small group market, the recent changes it has undergone, and the lack of time to address the issues fully, the Work Group suggested that no immediate changes be made to this market. The group suggested a full evaluation of the small group market rating rules and products as they stand, including an evaluation of the impact of individual market changes on the small group market. A policy change could be recommended if small groups are enrolled in exchange or disruption is found due to individual market changes. For more on the potential impact of individual market changes on the small group market, please see Appendix D.

Recommendation 4: Use the Essential Services Benefit Definition to Establish Product Foundation and Tiers

The Exchange Work Group's discussion of benefit design issues in the context of market reforms is based on the assumption that the OHFB Benefits Committee will define an essential services benefit that meets the individual health insurance requirement. The Exchange Work Group recommends that all insurance carriers participating in Oregon's individual market be required to offer a plan equal to the essential services benefit. In addition, each carrier may offer other plans that are "buy ups" from the basic benefit. To limit adverse selection to insurers based on plan offerings, plans at the richer benefit tiers would be actuarially defined so that a benefit plan in the

lowest tier is actuarially 60% of a plan in the third level. Determining the appropriate number of tiers will depend on the richness of the essential services benefit. The initial recommendation is to establish three to five standardized benefit tiers.

Other states' reforms have included the establishment of a Young Adult plan that differs from the foundation benefit required for other state residents, with a lower cost package with differences in cost sharing, benefits, and annual and lifetime limits. The Work Group decided that young adults should not be treated differently from other Oregonians. The group believes the recommended rate bands would allow carriers' plans to be attractive to young enrollees. An exchange could reassess this strategy if the cost of the essential services benefit is very high and the initial enrollment of young adults is low. In addition, the exchange could consider becoming more prescriptive with benefit plans if risk adjustment alone does not do enough to control risk selection.

Carriers would continue to file their plans with DCBS. The DCBS review would include a carrier demonstration that offered products meet or exceed the essential services benefit. All insurance products with benefits equal to or greater than the essential services benefit would be offered on guaranteed issue basis. The Work Group discussed but did not take a formal position on whether supplemental, location-specific and disease-specific plans would be subject to guaranteed issue. Such plans are generally not comprehensive, and more information and analysis is needed regarding supplemental plans not considered health insurance under state code.

Recommendation 5: Maintain Current Treatment of Self-Employed Sole Employees

Oregon's current market allows self-employed individuals who do not have other employees to buy insurance through the individual market, but not through the group market.[10] Self-employed persons are excluded from the group market in order to avoid adverse risk selection issues. In the absence of regulatory changes that align benefits and mandates in individual and group markets, the Exchange Work Group recommends no change in the treatment of self-employed persons without additional employees.[11]

Recommendation 6: Require All Employers Establish Section 125 Premium Only Plan

The overall goal of the Exchange Work Group was to recommend changes to the individual market that would improve access to affordable, appealing health coverage for Oregonians. The group discussed ways to make individual insurance more affordable to the widest range of people, including those not eligible for state premium contributions. While the recommendations of the Eligibility and Enrollment Committee would extend financial assistance to many people in the form of premium contributions or tax credits, other Oregonians earn income above the level that would qualify for such assistance. To make insurance more affordable for working

[10] In insurance lingo, a self-employed person with no other employees is sometimes referred to as a "group of one". This is different from an employee group in which only one employee takes up employer-offered insurance. This latter case is group coverage, and not affected by the above discussion.

[11] Once the Benefits Committee establishes a standard for an essential services benefit, further discussion may be required regarding differences between group and individual markets.

Oregonians who are not offered or eligible for employer-based coverage, the Exchange Work Group recommends the increased use of Section 125 Premium Only Plans (POP).[12]
The Work Group recommends that every Oregon employer establish a Section 125 Premium Only Plan, whether or not the employer offers health benefits to employees. A Section 125 POP allows employees to set aside pre-tax dollars for health benefits. An employee who uses a Section 125 POP to pay for health care coverage premiums on a pre-tax basis reduces the amount she owes in state income, federal income and Federal FICA taxes. Depending on the employee's income, the savings could be as much as 40% of the cost of health care coverage. When an employee uses a Section 125 POP, the employer saves on FICA withholding.

The Work Group would make an exception for employers that fund 100% of premiums in the employer sponsored plan. Such plans must be offered to all employees. This recommendation can be implemented immediately; however, Section 125 POPs would help the largest number of Oregonians only if the individual market was converted to guaranteed issue. Federal law only allows Section 125 POPs to be used for individual insurance premiums in a guaranteed issue individual market. Without a change to a guaranteed issue individual market, a Section 125 POP could only be used by employees to pay for their portion of employer sponsored health insurance plans.

It is fairly inexpensive for an employer to establish a Section 125 Premium Only Plan. Similarly, there is very little cost to the employer when an employee uses a Section 125 plan to pay for health care premiums on a pre-tax basis. There is a small administrative cost to the employer to set up a plan, but the cost is low and the process is easy. Many payroll firms offer this service as part of the benefits package they offer to small employers.

Recommendation 7: Ensure Oregonians Get and Keep Coverage

Insurance coverage for all Oregonians is one of the founding assumptions of the Oregon Health Fund Board. This principle led the Exchange Work Group to recommend an individual market based on guaranteed issue. Guaranteed issue only works if everyone eligible for the individual market participates. Without full participation, guaranteed issue can cause rates to rise to an extent that coverage becomes unaffordable for many people.

The majority of the group felt that to ensure participation, it must be easy to get coverage, and the individual insurance requirement must be strongly enforced. Several members argued that enforcement was only needed if education, enrollment incentives and other positive tactics were not implemented. Both inducements and penalties are discussed below.

The majority of the Work Group recommended a non-participation penalty of 50 percent of the cost of an average annual premium. The Finance Committee, when presented with the Work Group recommendations, recommended a larger penalty of up to 100 percent of the cost of an

[12] Section 125 of the Internal Revenue Code covers Premium Only Plans (POP), as well as plans known as "cafeteria plans." As the name implies, Premium Only Plans can only be used to pay for health insurance premiums. Cafeteria plans can be used to pay costs associated with accident and health benefits, adoption, dependent care, group-term life insurance coverage, and health savings accounts. The Exchange Work Group did not discuss cafeteria plans.

average premium. Some Work Group members recommended that instead of implementing a penalty, the state automatically enroll people and then work to collect individual premium contributions for the coverage, based on the income guidelines described in the Eligibility and Enrollment Committee's report.

In addition, after the Work Group finished meeting, a Staff Review Panel met to discuss ways to facilitate enrollment. The Staff Review Panel included members of the Exchange Work Group, Eligibility & Enrollment Committee and Health Equities Committee. In the discussion outlined below, we have noted where the ideas come from the exchange and where they are the thinking of the Staff Review Panel.

Encouraging Participation by Making it Easy to Enroll
To ensure participation, affordable, consumer-valued insurance must be made available to all individual market consumers. In addition, the application and enrollment process must be easy. Consumers must have access to understandable information on carriers' plan costs and benefits, as well as to enrollment assistance. An exchange can facilitate this process by making information available to consumers and providing a variety of enrollment services.

Individual Coverage Requirement
The Work Group discussed ways to ensure that the individual coverage requirement is enforced. This was seen as important for two reasons: (1) to ensure that rates are not artificially elevated by the existence of a guaranteed issue market in which people only enroll when they need medical care; and (2) to help ensure carriers remain in the individual market. The experience of other states that tried guaranteed issue without an individual health insurance requirement shows that it causes individual market rates to rise and reduces the number of people participating in the market.

Principles
The Work Group agreed on several proposed principles for enforcement of an individual insurance requirement. The first was "keep it simple." An overly complex administration process could hurt compliance and increase the cost of enforcement. An ideal enforcement strategy is easy to administer and makes it easy to comply and verify coverage.

An individual insurance requirement should be fair. People who can afford to purchase coverage should do so, while lower-income Oregonians should receive financial help to make coverage affordable. This also another addresses Senate Bill 329's call for individual consumers, the government, employers, providers and health plans to all share responsibility for financing and delivering health care.

The Work Group recognized that total compliance will be difficult to achieve and costly to pursue. As compliance reaches some threshold, the marginal cost of tracking down remaining non-participants goes up significantly, while the overall result of doing so decreases. The key is establishing a compliance goal that is high enough to significantly reduce the cost shift and minimize adverse selection.

The group agreed that a specified benefit was needed to define what it means to meet the coverage requirement. The Benefits Committee's Essential Services Benefit package was taken as a potential baseline, but the Work Group wanted more information about the affordability and utility of the package before making a definitive recommendation.

Possible Strategies for Encouraging Participation and Responding to Non-Compliance
The Work Group discussed ways to encourage participation and penalize those who do not get insurance. The group did not make definitive recommendations, but did identify several techniques. The group was in general agreement that participation goals should be met through positive encouragement as well as through penalties on non-participants.

Aggressive Marketing. The Work Group agreed that for an individual mandate and guaranteed issue coverage to be successful, individual market purchasers must have access to full information about the variety of plans available for purchase. Good information on plan details and costs, including comparisons across the plans must be accessible and easy to understand.

Use Multiple Sources to Identify the Insured. The Staff Review Panel recognized that education campaigns could greatly improve compliance with an insurance requirement. The panel discussed the need for targeted marketing, and discussed ways to figure out who lacks insurance in order to direct information to those people.

Panel members suggested using the existing structures with which people interact, including employers, schools, Department of Motor Vehicles, Department of Revenue (individual income tax), social security offices, libraries and social services agencies. While some services could be tied to providing information about enrollment, such as receipt of a library card or drivers' license, these agencies and organizations would be primarily used to identify the insured and uninsured rather than to impose penalties.

One panel member noted that employers currently file a Form 132 - Domestic (Annual Wage Detail Report) with the Oregon Department of Labor. The form identifies all employees, and could be amended to identify which employees have insurance coverage.

Open Enrollment Period. An annual open enrollment period would be designed to manage risk and provide time and assistance for new enrollees to choose coverage and people renewing coverage to select new plans. As is done with most employer coverage, individuals would be able to enter or change coverage only during a specified period during the year. Several Work Group members cited Medicare Advantage as a model for such an open enrollment system. Other members questioned whether an open enrollment period was necessary or desirable, suggesting that people should be allowed to enroll when they needed care. However, the majority felt that open enrollment would provide an opportunity for people to enroll after accessing comparable information from plans, and would limit rate increases due to enrollment only at moments of service need.

People who recently left employer sponsored coverage, moved into the state or who had some other qualifying "life change event" could enter individual coverage at other times of year, but

someone who had decided not to enter coverage during the open enrollment period would not be able to get coverage until the following year's open enrollment.

An appeals and enrollment-period exceptions process will be developed, and procedures established to recognize situations in which an individual has a reasonable claim to enter the individual market or switch carriers outside of the open enrollment period.

Someone entering coverage after previously choosing not to get insurance would only be able to enroll in the lowest tier of coverage, a plan equal to the essential services benefit. After a year in an essential services benefit plan, this person may then enroll in any other tier of care at the next open enrollment period. In addition, rules will be developed regarding who is responsible for ensuring that minors and other dependents receive insurance coverage, and how this process will work.

The state will develop processes for ensuring that insurance carriers participate in the open enrollment period process. The Work Group will work with the Eligibility and Enrollment Committee regarding residency requirements for state premium contributions.

In addition to providing Oregonians with information about coverage options and offering enrollment assistance, an annual open enrollment period can reduce the number of people who remain uninsured until they need services. Allowing people to enter coverage at any time would remove the incentive for Oregonians to get insured before illness or injury occurred. With a lower proportion of healthy individuals in the pool, the price of insurance would go up for the insured. This would discourage insured healthy people from maintaining coverage, further accelerating a cost spiral.

Quarterly Rates. Another way to encourage timely enrollment is to set quarterly premium levels, with rates set lower for those who enroll early. An individual who waits several months to enroll would see a higher premium cost related to the quarter in which he enrolled. This incentive to early enrollment would reflect the higher cost of health care for those who wait to enroll until coverage is needed, and would provide a discount to those who enroll at the start of the coverage year.

Auto-Enrollment. The Work Group considered auto enrollment for people not enrolled in other coverage, but did not come to a consensus on the issue. Several questions were raised during the discussion, including how premiums would be collected from those who are auto-enrolled in coverage, and how to identify who should be enrolled. The Staff Review Panel suggested a combination approach that would pair auto-enrollment and payroll deduction for uninsured employees.[13] As described above, employers could be required to identify whether employees had coverage, potentially by using DOL Form 132. The state could deduct the premium cost (adjusted for income) from the payroll of employees who did not enroll in coverage on their own. The combination of employer tax and individual deduction would automatically enroll the individual into a minimum benefit plan through the exchange.

[13] This idea was discussed by the Staff Review Panel but not approved by the Exchange Work Group.

While auto-enrollment may show promise with populations that are historically resistant to health insurance enrollment, more work is needed to identify ways that auto-enrollment could increase participation while maintaining financial integrity for the state and health insurance carriers.

Financial Penalty for Non-Participation. The one technique that most Work Group members supported was the imposition of a significant financial penalty on non-participants. The Work Group endorsed a penalty equal to 50% of the yearly premium for an average individual insurance package. When the issue was raised at the Finance Committee, many Committee members supported a penalty as high as 100% of average premium. Implementation would require a change in the state tax forms and coordination between Department of Revenue, Department of Labor, Department of Human Services, and the health plans.

School Enrollment Health Insurance Requirement. Another possibility discussed at the staff review panel on an individual mandate, but not at the Work Group, would be something similar to Oregon's compulsory immunization law, ORS 433.275, that requires children be immunized prior to enrollment in school. There could be a similar law that requires children to have health insurance prior to enrollment.

Additional Enforcement Issues

A number of additional issues were raised in the discussion of how to implement an individual insurance requirement. The Work Group identified several issues for further development by the Board or the entity charged with ensuring Oregonians participate in health coverage. Rather than make specific recommendations on these issues, the group recommended additional work be done in the following areas:

- What essential benefit package meets the coverage requirement? How limited or comprehensive is the benefit?
- How will the benchmark benefit affect people with access to employer sponsored insurance?
- How will incentives and penalties, both of which are necessary, be balanced?
- Will compliance be monitored through the tax system and/or another mechanism?
- What entity will determine compliance? What entity will administer penalties?
- How will compliance be determined? How often will it be assessed?
- What period will count for having insurance (start or end of the year, 12 months)?
- Will there be any exceptions to the coverage requirement? What will they be?
- What will the appeals process look like?

Recommendation 8: Additional Work is Needed in Several Areas

Explore Alternatives if Mandate is Not Enforced or Subsidies are Not Available

The Exchange Work Group based its market reform recommendations on the assumptions that there will be an enforced individual insurance requirement and state premium contributions for lower-income individuals. If either the individual insurance requirement or state premium contribution system is not implemented, the Work Group would not want to move forward with

Recommendation 1 (guaranteed issue and a merged individual market). Additionally, Recommendation 2 (implementing a risk adjuster) would not be needed.

If an individual insurance requirement or premium assistance program was not implemented, the Work Group would recommend making changes to the existing individual market. Additional work would need to be done if this option was pursued.

The Work Group recognized that whether or not changes were made in the small group market, changes in the individual market would impact small groups. As described elsewhere in the report, some Work Group members thought that small group reforms should be done in tandem with changes to the individual market. Others wanted to wait to tackle the small group market until the first set of reforms were implemented. The whole group agreed that additional work should be done to assess the consequences of individual market changes on the small group market. Of particular interest were (1) whether and how to merge rate bands and rating rules for the two markets; and (2) whether, when and on what basis to enroll small groups in an exchange.[14]

[14] For more on this latter issue see the section of the report entitled "Health Insurance Exchange Recommendations."

DESIGNING A HEALTH INSURANCE EXCHANGE

With the reformed individual market just discussed, the Work Group turned to the concept of using an exchange to support the mandatory enrollment of individuals using direct and indirect state premium contributions and to administer subsidies. A health insurance exchange is a market organizer that facilitates the purchase of health insurance. It is a tool that works best as part of a larger set of market reforms.

While the majority of the Work Group agreed that an exchange would be beneficial, several members felt an exchange was not needed. These members believe that the Family Health Insurance Assistance Program (FHIAP) and health insurance agents and brokers perform many of the functions of an exchange. They argued that FHIAP could take on additional roles as needed. As the majority agreed to pursue the charge outlined in the Work Group charter to develop recommendations for an exchange, the group spent considerable time discussing the potential roles, populations, administrative structure and financing of an exchange. The majority saw the exchange as providing valuable functions, including: administering state premium contributions; facilitating consumer understanding of available options; and easing enrollment an providing pre- and post-enrollment customer service in conjunction with carriers and agents/brokers.

In developing its exchange recommendations, the Work Group made the following assumptions: (1) all of the reforms described in the Market Reform recommendations will be implemented; and (2) consumers will be offered a range of affordable plans with benefits that are attractive to them. The following outlines the Work Group's recommendations.

For more on the group's analysis that led to these recommendations, please see Appendix C, which contains the goals for an exchange and details on the analysis that behind the recommendations.

HEALTH INSURANCE EXCHANGE RECOMMENDATIONS

Recommendation 1: The exchange should operate as a strong market organizer by standardizing benefits and establishing performance benchmarks across carriers.

The Work Group did not come to a full consensus about the tier at which an exchange should function. Everyone agreed that an exchange should serve to provide information, enrollment and administration functions (Tier 1). The group was in general agreement that an exchange should also take on a strong role in moving the market by standardizing benefits offered by carriers, establishing performance benchmarks across carriers, and contracting with carriers that meet these standards (Tier 2). Half the group supported an exchange negotiating rates and selective contracting (Tier 3), but several other members expressed significant concern that Tier 3 could limit carrier participation. The group agreed that a strong Tier 2 could achieve most, if not all, of the goals as well as a Tier 3 function could. In addition, a Tier 3 exchange can not be achieved in a dual market with voluntary use of the exchange.

The group agreed that all carriers that meet the benchmark standards could contract to offer coverage through the exchange. Work Group members also agreed that Tier 2 functions should be viewed as a continuum, depending on the strength of the required performance benchmarks. If the standards were set relatively low, there would be more carriers participating. If standards were set relatively high, fewer carriers would be able to participate.

Recommendation 2: Require the exchange for individuals receiving state premium contributions or using tax credits for premium purchase and those without access to employer sponsored insurance who want to use Section 125 Premium Only Plans to reduce costs; make the use of the exchange optional for other populations.

- The Work Group identified the following categories of individuals as the core of the insurance exchange and as the populations that should be required to enter the exchange to purchase insurance in the individual market:
  A. Individuals receiving direct state premium contributions (income 150-300% FPL)
  B. Individuals receiving tax credits for premium purchase (income 300-400% FPL)
  C. Individuals working for non-offering employers, who use Section 125 plan for premium purchase (income above 400% FPL)

  Many people in these three categories are currently uninsured; the exchange would offer services to help them purchase coverage as well as assure continuity of coverage and care. As discussed above, an exchange operating at Tier 2 or 3 could help maximize the value of government contributions (including premium contributions, tax credits and taxable income exclusions). Individuals in Category C (those working for non-offering employers) often work for so-called "micro-employers" that employ few employees.

- The Work Group recommends that people with income above 400% FPL not eligible for employer coverage (Category D) enroll in the exchange based on *employer* discretion. To reduce risk selection but maintain employer choice, the Work Group agreed that employers should be given the option of allowing ALL employees fitting into Category D to enter the exchange or to get insurance in the direct individual market. This choice must be made for all employees in this category, so that high cost or older employees are not directed one way while others go another. Assuming the requirement that all employers offer Section 125 premium-only plans, these employees would have access to pre-tax dollars to purchase insurance.

- The Work Group recommends allowing self-employed or non-employed with income above 400% FPL (Category E) to choose either the exchange or the direct market. A majority of the group supported allowing these individuals to choose between entering the exchange and getting insurance through the direct market. Some members asserted that the exchange would be stronger if it had all individual purchasers; others think that an exchange that has to prove itself will work better and offer more value to consumers. When this issue was presented to the Finance Committee, the majority of the group preferred a voluntary solution.

  The Work Group asserted that allowing voluntary choice for this group should be tied to the implementation of the individual market reforms laid out in the first section of the report.

The individual market must be accessible and appealing to individual consumers, whether they enter through the exchange or go direct.

For more details on the Work Group discussion on this topic, see Appendix C.

Recommendation 3: The structure of the exchange should facilitate accountability, transparency and responsiveness, while supporting flexibility and market responsiveness.

The Work Group wanted the exchange to be an entity that is strongly responsive to the public that it serves, with the agility of a private company. Although the group did not recommend a particular administrative structure, there was general support for a public entity that balances public accountability with responsiveness. Hybrid public-private organizations that exist in Oregon and elsewhere could be used as models for the exchange.

Recommendation 4: The exchange should be relatively self-supporting.

The Work Group agreed that, after some initial start up period, the exchange should be partially or fully self-sustaining. Some members supported the use of State General Fund dollars, but no one thought that the General Fund should be the only source of funding for the exchange. The group agreed that over-reliance on the State puts the work of the exchange in jeopardy during economic downturns or periods in which the exchange's work is not supported by the majority party. In concept the Work Group supported the use of a fee and other sources of funding, but did not reach a consensus on the actual sources to be used or how much funding should come from which source. The group recommended that the Board evaluate the likely cost of an exchange in order to determine the true amount of required financing.

Recommendation 5: Do not initially enroll small employer groups in the exchange.

The Work Group recognizes that small employer groups could benefit from access to an exchange. While some members believe that the small group and individual markets should be immediately merged and groups granted entry into the exchange, others were concerned that the policy and administrative goals of doing so are not yet clear enough to fully develop a plan for including small groups. To do so will require consideration of several issues, including: the role of the small group pool; the differences between the individual and small group markets; the impact of changing rates and market rules in the small group market; and how to manage adverse selection in a voluntary exchange.

Some members believe that the benefit to small employer groups would be significant enough to justify the administrative complexity of offering an exchange's services to small groups, while the majority raised significant concerns about adverse selection. This led the group to recommend that the development of an exchange in the individual market should be the first focus. The majority of the group wanted to hold off on further development of a plan for group participation until the exchange establishes itself and goals for group participation can be clarified.

While the majority of the Work Group did not support immediately opening the exchange to employer groups, several members expressed the hope that once the exchange is well-established in the individual market, groups could be given the opportunity to participate. The Work Group members that supported more immediate entry of small employer groups into the exchange propose a two to three year transition period, in which the small employer group and individual markets are merged and rates were set on risk and experience across both markets.

The Work Group recognizes that in the current scenario, employers that are currently providing insurance to employees may decide to drop group coverage in order to provide their employees access to the exchange.

Appendix A
Exchange Work Group Membership and Staff

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Appendix B
Merging Oregon's Individual Markets

June 2008

Overview of Methodology and Results

The Mosier Group LLC was asked to estimate the impacts of merging several segments of the population into a combined individual insurance market. The segments included:

- People with individual health insurance today;
- Those enrolled in the Oregon Medical Insurance Pool (OMIP);
- Members insured under Oregon's Portability Provisions; and
- The currently uninsured, who would be projected to join a merged commercial market for individual health insurance.

At a high level, the results show that those in today's individual market would likely experience premium increases of about 14% to 21% -- largely because today's rates reflect the healthier than average population achieved through the health underwriting process. Conversely, those members in OMIP and Portability categories would see rate reductions of between 13% and 33% when blended with the healthier members of today's individual market. Details of the data and assumptions required, a summary of the methodology, and tables of results follow.

Data and Assumptions

Population and General

Oregon population assumptions are drawn from two sources.

- "Covering the Uninsured: The Cost to Oregon" by John McConnell, Gretchen Morley, Nora Leibowitz, and Tina Edlund published in January 2007
- "Health Insurance in Oregon 2007" by the Department of Consumer & Business Services

Medical inflation from 2007 to 2008 was assumed to be 8%.

Individual Market

For today's individual market we used 2007 filings for 5 large carriers to derive an average cost, which was then generalized to the entire current individual market. Several assumptions were required to make these generalizations:

- An aggregate medical loss ratio of 85% was used to convert costs to premiums
- We assumed that the average cost sharing (deductibles, copayments, etc) for this population would be 25%

Using these figures, the current individual premium per member per month was estimated to be $218.

Portability

The Portability market is designed to provide health insurance coverage to members who lose employment-related coverage with a comparably priced premium. For those employees leaving fully-insured employer coverage, the insurance carriers provide these packages, for those leaving self-insured employer coverage it is provided by OMIP. Because of limited data for this population, we made a series of assumptions to estimate costs. First we used carrier filings for large employer coverage to develop a premium baseline. Next we needed to estimate the implicit subsidy since there is known adverse selection for this population. Because of a lack of carrier Portability data, we relied on the excellent data available from OMIP to estimate this subsidy. These estimates were then generalized to the Portability population. Key assumptions include:

- Allowed charges are 188% of baseline premium, paid claims are 148% of baseline premium
- Administration costs were assumed to be equal to those of the individual market population

Using these figures, the current average Portability premium per member per month was estimated to be $304.

OMIP

Estimates for OMIP were pulled directly from the OMIP Stat Pack dated February 2008 and from custom data runs provided by OMIP.

Based on this information the average OMIP premium in our model was estimated at $372.

Uninsured

We used the estimates from "Covering the Uninsured: The Cost to Oregon" as a baseline for how many of the currently uninsured would join the merged market, and not end up in some form of public or employer-based coverage. In addition we used results from "Covering The Uninsured: How Much Would It Cost?" and "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" by Jack Hadley and John Holahan to estimate the relative costs of the uninsured and the increased demand expected upon becoming insured. Other assumptions include:

- Assumed cost sharing in plan 25%
- 85% loss ratio

Using these assumptions the hypothetical premium for the uninsured before merging the populations was estimated at $277.

Methodology and Results

For each subpopulation we used the data and assumptions described above to create a table showing the size of each subpopulation and their costs expressed in the following ways:

- **Allowed Charges** – this represents all the health care use of the population on a per member per month basis
- **Paid Claims** – represent the portion of Allowed Charges paid by the health plan (not by member payments of deductibles, coinsurance, or copayments)
- **Full Premium** – is Paid Claims plus health plan administrative costs
- **Member Premium** – is intended to be, on average, the amount actually paid monthly by covered persons and differs from the Full Premium for the OMIP and Portability populations because of the implicit subsidies underlying current rating requirements.

In order to assess the impacts on the individuals who would comprise the merged market, we focused on the Member Premiums before and after consolidation of the market. We calculated the change in rates two ways. The first calculation in Table 1 below shows the impact of combining these populations and concurrently eliminating the current assessment which supports OMIP. The columns on the far right show the impact if the assessment for OMIP is retained and spread over the new combined population.

Table 1

	Number of Members	Today's Member Premium PMPM (after subsidies for Portability and OMIP)	Pooled Premium All populations (no OMIP assessment)		Pooled Premium All populations (retain OMIP assessment)	
			Premium	% change	Premium	% change
Individual	200,000	218	265	21%	249	14%
Portability	19,000	304	265	-13%	249	-18%
OMIP	17,192	372	265	-29%	249	-33%
Uninsured (likely to join individual market)	112,000		265		249	

We were also asked to run a scenario where the OMIP population continued to stand alone – not becoming part of the merged individual market. Results for this scenario are shown below.

Table 2

	Number of Members	Today's Member Premium PMPM (after implicit Portability subsidy)	Pooled Premium Individual, Portability, Uninsured	
			Premium	% change
Individual	200,000	218	243	11%
Portability	19,000	304	243	-20%
Uninsured (likely to join individual market)	112,000		243	

These figures were presented to the Exchange Work Group on 4/30/2008.

Additional Analyses

We were asked to perform several additional analyses subsequent to the Exchange Work Group meeting. These are summarized below.

Reassess OMIP Portability Data

OMIP was judged to be the best data source for the Portability population costs, however the OMIP total population included the Portability members as well. The result was double counting approximately 2,200 individuals who were in both Portability and OMIP counts. Although the impacts are small, Table 1 is restated below:

Table 1 Restated

	Number of Members	Today's Member Premium PMPM (after subsidies for Portability and OMIP)	Pooled Premium All populations (no OMIP assessment)		Pooled Premium All populations (retain OMIP assessment)	
			Premium	% change	Premium	% change
Individual	200,000	218	263	20%	248	14%
Portability	19,000	304	263	-14%	248	-18%
OMIP	15,000	369	263	-29%	248	-33%
Uninsured (likely to join individual market)	112,000		263		248	

Sensitivity Analysis on Uninsured

Because the estimates of the uninsured are assumption driven, we agreed to perform a sensitivity analysis on these assumptions. In our baseline assumption set, the uninsured who are likely to join this merged market had costs approximately 27% higher than the individual market average and about 2% above the pooled average of the Individual, Portability and OMIP markets. We ran scenarios assuming the uninsured estimates were 10% high or 10% low, these are summarized in Table 3 and Table 4 below:

Table 3 – Uninsured with 10% Higher Cost

	Number of Members	Today's Member Premium PMPM (after subsidies for Portability and OMIP)	Pooled Premium All populations (no OMIP assessment)		Pooled Premium All populations (retain OMIP assessment)	
			Premium	% change	Premium	% change
Individual	200,000	218	272	25%	257	18%
Portability	19,000	304	272	-11%	257	-15%
OMIP	15,000	369	272	-26%	257	-30%
Uninsured (likely to join individual market)	112,000		272		257	

Table 4 – Uninsured with 10% Lower Cost

	Number of Members	Today's Member Premium PMPM (after subsidies for Portability and OMIP)	Pooled Premium All populations (no OMIP assessment)		Pooled Premium All populations (retain OMIP assessment)	
			Premium	% change	Premium	% change
Individual	200,000	218	254	16%	239	10%
Portability	19,000	304	254	-17%	239	-21%
OMIP	15,000	369	254	-31%	239	-35%
Uninsured (likely to join individual market)	112,000		254		239	

Appendix C
Exchange Goals and Analysis

EXCHANGE GOALS

Before identifying who should use an exchange and what functions might be performed by a proposed exchange, the Exchange Work Group identified the following goals:

Help consumers shop for insurance. Provide consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.

Make it easy for consumers to enroll. Provide an efficient and user-friendly mechanism for enrollment in health plans.

Help consumers and insurers with Payment Processing. Provide a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.

Help consumers by offering customer service. Offer information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.

Encourage carriers participate in the exchange. Streamline the marketing and enrollment functions and by protect carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.

Make it easy for consumers to compare options. Standardize or categorize benefit plans offered by carriers.

Offer choice to consumers. Ensure that consumers have a choice of multiple carriers, providers and delivery systems.

Lower costs and improve quality for consumers by encouraging innovation and improvements in the quality and efficiency of the delivery system. For example, the exchange could establish standards for carrier participation, evaluate carriers and their provider networks, encourage innovations in provider payment, and encourage healthy competition based on quality and efficiency.

Lower costs and improve quality for consumers by encouraging innovation and improvements in insurance administration. This could occur through incentives for efficient administration and effective customer service, for example.

Maximize the benefit of government premium contributions to low-income people. Ensure that taxpayer dollars are deployed to obtain the best value.

Minimize the disruption for current (mostly self-pay) consumers in the individual market.

Encourage carrier participation in the individual market. Participation should be encouraged regardless of the presence and role of an exchange.

Facilitate coverage seamlessness for consumers. Make it easy for consumers to move between subsidized and non-subsidized individual coverage, as well as between individual and small group coverage.

Facilitate the task of managing risk selection. Appropriate management of risk selection will help avoid an adverse risk spiral in any market segment.

ANALYSIS: EXCHANGE FUNCTIONS, PARTICIPANTS, ADMINISTRATION AND FINANCING

Potential Functions and Roles of an Exchange

While most members of the Work Group supported the idea of a health insurance exchange, several members were not sure that one was necessary in Oregon. These members felt that the Family Health Insurance Assistance Program (FHIAP) performs many of the roles that an exchange could play, and if additional functions were needed FHIAP could be expanded to meet those needs. They also argued that agents and brokers currently perform many of the customer service functions that an exchange might be asked to perform. Further, they worried that an exchange could disrupt the working relationships that agents and brokers have with both consumers and insurance carriers.

As the Work Group charter specifies that the group should explore the roles an exchange could play in a reformed individual market, the Work Group noted the dissenting views but agreed to investigate the potential roles and participants of an exchange. The group first dealt with the possible functions and roles of an exchange, and identified a range of options, from a relatively narrow role with a limited set of functions, to a broader role with more functions. For the discussion of the services an exchange could perform, functions were grouped into "tiers." An exchange could provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

Tier 1. Information, Enrollment and Administration
The functions of an exchange operating under Tier 1 could include:

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans;
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans;
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment;
- Establish a process to confirm eligibility and administer government contributions for low-income individuals;

- Assist employers and others (as permitted by law) to set up and administer Section 125 plans to allow certain individuals to qualify for tax-exempt health benefits, as for employees who work for employers not offering health benefits;
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, for example, for employees who work part-time for multiple employers that do not offer full health benefits;
- Ensure provision of customer services, for example, provide (or coordinate with brokers and carriers) to provide information, support, advocacy and referral for problems regarding benefit interpretation, claims payment, and other services;
- Work with DCBS to train agents and brokers on exchange functions. Brokers and agents will continue their current role in the individual and small group markets; facilitate individuals getting connected to licensed agents/brokers who know about public programs; and
- Administer mechanisms to protect insurers who enroll high-risk members, for example, risk adjustment or reinsurance.

Tier 2. Benchmarking and Standards
An exchange that operates at Tier 2 provides all of the functions that a Tier 1 exchange provides, but it also serves the following roles:

- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection;
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information);
- Establish agent and broker role in distribution and marketing of plans offered in the exchange;
- Contract with plans for insurance products that can be purchased through the exchange; and
- Innovate by contracting for complete packages of products and services from the carriers, or by allowing the exchange to contract separately for benefits or services that might better achieve benchmark performance.

Tier 3. Rate Negotiation and Selective Contracting
An exchange that operates at Tier 3 would perform all Tier 1 and Tier 2 function, in addition to the functions listed below:

- Solicit bids or price proposals;
- Negotiate prices and/or discounts with carriers; and
- Select which carriers would participate in the exchange.

After determining the possible functions of an exchange, the Work Group outlined the pros and cons of having the exchange exercise a given range of functions. The group did not reach unanimity regarding the roles an exchange should play, but was in general agreement that the exchange should perform functions from tier two or three. Work Group members had a range of

views about the functions an exchange should provide and the extent to which an exchange working a various tiers achieved the goals outlined above.

Discussion: Tier 1 Exchange
The services would be limited to marketing, consumer information, and subsidy administration. Many of these functions exist in the market, though some would be new. Given the limited amount that would be new, a large investment in an exchange may not be worth while. It would not offer added value for the expense.

Discussion: Tier 2 Exchange
Added value – more pressure on carriers to implement cost containment, quality improvement.

Some in the group felt that a broader role for the exchange would help lower costs and improve quality for enrollees. These members argued that consumers acting alone cannot move the market; that by setting standards and contracting with plans that meet those standards the exchange would be able to drive more change in the marketplace. In this model, consumers make choices among carriers (and their affiliated provider networks) in a more structured market.

Discussion: Tier 3 Exchange
It can be argued that the competitive model implicit in both of the above approaches is not effective due to the special nature of the health care market. In that case, an exchange must be able to negotiate rates and selectively contract with carriers.

Many of the information, enrollment and administration services are currently provided by insurance brokers and agents. If Oregon develops an exchange, it will be important to determine an appropriate role, appointment process and payment structure for brokers and agents. If the exchange operates at Tier 1 brokers and agents would likely continue their current role in the individual and small group markets. If the exchange operates at Tier 2 or 3, it may be appropriate for brokers to be certified by the exchange and appointed jointly by the exchange and the carriers. The exchange might also want to use a broker payment structure based on something other than a percentage of premiums.

Categories of Potential Exchange Participants
After identifying the goals of an exchange, the Work Group discussed who may or must obtain health insurance through the exchange. The following were identified as the categories of potential participants:

A. Individuals receiving state premium contributions (income between 150-300% FPL)[15]
B. Individuals receiving tax credits for premium purchase (income between 300-400% FPL)
C. Individuals working for non-offering employer, who use Section 125 plan (income above 400% FPL)

[15] The eligibility standards for categories A and B come from the Eligibility and Enrollment Committee's recommendations to the Oregon Health Fund Board regarding what Oregonians should receive direct or indirect state premium assistance. The Committee's report is available at: <http://www.oregon.gov/OHPPR/HFB/docs/EEAffordabilityRecommendations_Final.pdf>.

D. Individuals who are not eligible for the insurance offered by their employers, but who can use a Section 125 premium only plan (income above 400% FPL)
E. Self-employed or non-employed individuals with income above 400% FPL
F. Employees of small employer groups (2-50 employees)
G. Employees of medium and large employer groups (over 50 employees)

Impact of Including More Populations in the Exchange

Part of making an exchange viable is utilizing its market power to push for delivery system changes that could benefit all consumers in Oregon. Increasing the size of the exchange population helps meet the identified goals of improved consumer shopping and customer service, easy enrollment, and streamlined payment processing. Allowing or requiring entry by more categories of enrollees would bring these services to more people. Further, any market changes the exchange encourages on behalf of enrollees could help others not enrolled in the exchange, as the exchange moves the market to adopt stronger quality standards for all insurance.

In addition, a larger pool would spread fixed administrative costs over a larger base, thereby reducing the cost for each participant. This benefit is significant as the pool expands to a certain level (around 100,000 participants), but the incremental benefit is small as the pool grows even larger. A larger pool also spreads risk broadly, providing more stability for the pool over time and potentially lessening the danger of an adverse risk spiral. As with spreading fixed administrative costs, the benefit of this is significant up to a certain level, but the incremental benefit is small as the pool grows beyond that.

Further considering the goals of lowering costs and improving quality, a larger exchange could have even more influence in the market if it worked closely with other large public and private purchasers. The ability of an exchange to coordinate with other purchasers depends in part on the role that the exchange chooses, especially if it set high performance benchmarks for carrier participation in the exchange.

Including categories of people other than those receiving direct or indirect state premium assistance raises logistical and other issues for the exchange. Some of these issues may offset the general advantages of increasing the exchange's size. The pros and cons of including each category are described below.

Categories A, B, C: Individuals Accessing State Financial Assistance

The Work Group identified the following groups as the core of an insurance exchange:

A. Individuals receiving direct state premium contributions (income 150-300% FPL)
B. Individuals receiving tax credits for premium purchase (income 300-400% FPL)
C. Individuals working for non-offering employers, who use Section 125 plan for premium purchase (income above 400% FPL)

Most of the people in these three categories are currently uninsured; the exchange would offer services to help them purchase coverage. As discussed above, an exchange operating at level 2 or 3 could help maximize the value of government contributions (including premium contributions, tax credits and taxable income exclusions). Individuals in Category C (those working for non-offering employers) often work for so-called "micro-employers" that employ few employees.

Lower-income employed people often move between subsidized and unsubsidized coverage. Approximately 70% of individuals employed by non-offering employers are subsidy-eligible at a given time. Of the remaining 30%, some will be eligible for a tax credit; the rest can use a Section 125 plan to reduce their premium cost. Requiring everyone getting direct and indirect state assistance use the exchange would ensure continuity of coverage and care for them as they move in and out of subsidy eligibility. Allowing employer choice regarding use of the exchange would be akin to allowing individual choice for 125 users, as these employees work for the smallest firms.

Category D: People with Income above 400% FPL not Eligible for Employer Coverage, using Section 125

Individuals who fit Category D have income above 400% of the federal poverty level and are not eligible for the coverage offered by their employers. This is relatively small population, which includes many part-time employees and those in a waiting period for employer-sponsored coverage. Such individuals can reduce their premium costs by putting money into Section 125 plans set up by their employers.

The Work Group discussed whether individuals falling into Category D should be allowed to choose whether to purchase individual insurance through the exchange or in the direct market. The group agreed that allowing individual choice for this group could lead to adverse selection. To manage risk selection, all employees of a given employer who fit this category must either go through the exchange or go to the direct market. Due to the Employee Retirement Income Security Act (ERISA) employers can not be required to direct "category D" employees into the exchange. Members recognized that some employers might prefer their employees go to the direct market, especially if the carrier used for employer's group plan is not available in the exchange. Other employers will see the benefit of the exchange's purchasing power working on their employee's behalf.

Category E: Self-Employed or Non-Employed with Income Above 400% FPL

The Work Group identified three options for Category E individuals (self-employed or non-employed individuals with income above 400% FPL):

1. Require them to use the exchange (consolidate the individual market);
2. Allowing participation in the exchange or purchase outside the exchange (create a dual market with a "permeable wall"); or
3. Do not allow them to participate in the exchange (create a dual market with an "impermeable wall").

The Work Group assessed the pros and cons of the three options for individuals in Category E. Two-thirds of the group felt that these individuals should be allowed to choose whether to participate in the exchange or purchase coverage outside the exchange. The others argued that all individual market purchasers should access coverage through the exchange. These members expressed concern about risk adjustment and the cost of administration in a voluntary scenario. Others indicated that the success of voluntary entry for Category E depended on how well the exchange was able to drive value and convince consumers of it worth. No one supported excluding Category E from the exchange.

Factors Considered

In its assessment of the options for Category E, the Work Group identified and discussed the positives and negatives associated with requiring enrollment, allowing choice or excluding the population.

	Pros	Cons
1. **Require enrollment in exchange**	• Avoids adverse selection spiral in the exchange • Seamlessness – easier to move between subsidized and unsubsidized coverage without changing carrier • Increases access to exchange services • Increases population to spread exchange's fixed administrative costs • Larger population improves exchange's ability to make overall market change (esp. working with other purchasers such as PEBB)	• May be more disruptive to individuals if their current carrier is not in the exchange • Increases pressure on exchange to offer superior service, products (could be seen as a pro)
2. **Allow, but do not require participation in exchange**	• Allows the exchange to prove its value as consumers "vote with their feet" • Less disruptive - allows individuals to stay with their current carrier • Increases access to exchange services • Increases population to spread exchange's fixed administrative costs	• Danger of adverse risk selection unless regulatory and administrative steps are taken • Increases administration and regulation of the individual market • Could discourage insurers from participating in the exchange, which could reduce choice within the exchange • Increases complexity of risk adjustment and increases possibility of undermining behavior by carriers • Increases complexity for consumers
3. **Do not allow enrollment in exchange**	• Avoids adverse selection spiral in the exchange • Less disruptive -- allows individuals to stay with their current carrier	• Less seamlessness – people moving between subsidized and unsubsidized coverage may have to change carriers

Category E: Small Employer Groups

The Work Group identified and discussed the positives and negatives associated with requiring enrollment by small employer groups (2 to 50 employees), allowing choice or excluding small groups. The following table says out the pros and cons discussed.

Option	Pros	Cons
1. Require small groups to use exchange Combine individual and small group markets	• Avoids adverse selection spiral in the exchange • Seamlessness – easier to move between individual and small group coverage without changing carrier • Simplifies enrollment process • Merging the individual and small group markets would reduce variation in premiums • Allows employers to simplify benefits administration • Increases size (and potentially purchasing power) of exchange • Provide access to subsidies for people with employer sponsored coverage	• Potential for "rate shock" for older enrollees • May be more disruptive to individuals if current carrier does not participate in the exchange • Increases pressure on exchange to offer superior service, products (could also be seen as a positive) • Could require alignment of rating rules between individual and small group markets; combination of individual and small group market risk pools
2. Allow, but do not require use by small groups Dual market with "permeable wall"	• Increases choice of plans • Allows employers to simplify benefits administration • Provide access to subsidies for people with employer sponsored coverage	• Significant danger of adverse risk selection in the exchange or outside group market • Could require alignment of rating rules between individual and small group markets; combination of individual and small group market risk pools
3. Do not allow small groups to use exchange Small group and individual markets are separate	• Avoids adverse selection spiral in the exchange • Avoids possibility of "rate shock"	• Would not let small employers and employees get exchange's benefits (consumer choice, lower employer administrative costs) • Employers may drop coverage to allow employees to get benefits of exchange as individuals • Less seamlessness – people moving between individual & group coverage may have to change carriers

Building an Exchange: Administration and Financing

Once it had established roles for an exchange and populations that could participate in it, the Work Group discussed the potential governing structure of an exchange.

Administrative Structure: Key Characteristics

The Work Group identified several key characteristics for an exchange. The group felt the most important features are strong accountability and transparency, and responsiveness to stakeholders and the public. In addition, the group wanted the exchange to be relatively nimble and able to

respond to the market as needed. This led the group to discuss the following features of a possible governance structure: contracting and procurement are streamlined and responsive to the exchange's needs; financial accounting and reporting that is rigorous and transparent; personnel policies that facilitate hiring of and support for strong employees; salary policies that allow flexibility in compensation to offer industry competitive salaries; and independence and statutory decision making authority.

Structural Models

Three general structural models were discussed: public; private; and a hybrid model. Several hybrid models were discussed, including an independent public corporation (e.g., SAIF), an independent public agency (e.g., the Massachusetts Health Insurance Connector Authority), a nonprofit corporation (e.g., the Energy Trust of Oregon), and a governor-appointed citizen panel such as Oregon's Environmental Quality Commission.

The majority of the Work Group preferred an organization with the accountability and transparency of a public agency and the flexibility of a private organization. Members' views of whether the exchange should be public, private or a hybrid depended on whether the exchange would be open to non-subsidized individuals and small groups on a voluntary or required basis.

Some members raised questions about how to set up an exchange administration that was both responsive and agile. The group received input that in a public or hybrid model, authorizing legislation could be written to waive specific provisions of law, such as procurement or personnel policies. The group was told that the more specific the direction regarding what the hurdles are, the more targeted legislative exceptions language can be. A public or hybrid organization with flexibility written into its legislation helps ensure that the entity is both able to function in a quickly changing environment and that it remains open and responsive to the public, its members and other stakeholders. Roughly half of the group supported a hybrid model, while others preferred a public entity. One member liked a private non-profit structure.

Financing the Exchange

The Work Group agreed that the exchange needs a funding source that allows it to provide services on behalf of its members. Before discussing the source of such funding, the group developed a list of principles to guide the discussion.

The exchange requires funding that is stable, sustainable and adequate over time. The source should be broad-based and minimize the impact on any single payer. Funding should not provide a disincentive to any carrier, consumer or employer participate in the exchange. Payers should benefit, either directly or indirectly, from the services provided by the exchange. It should be clear to payers and others how the funding sources support the work of the exchange.

Options and Implications

Several funding sources were discussed. The first was a proposal to add a fee to the administrative portion of premiums paid through the exchange. This fee would be paid by enrollees not eligible for state premium contributions or tax credits, as well as by the state on behalf of individuals accessing contributions or credits.

While the medical components of the rates in and outside the exchange would be the same, an increase in the administrative component raises the cost of coverage through the exchange. However, it also clearly ties the fee to the benefit for enrollees. It also provides an incentive for the exchange to have an efficient administrative structure. A fee added to the administrative component of rates is less broad-based than some other sources, as the burden falls primarily on the insurers, groups, and consumers that participate in the exchange.

The group also proposed utilizing direct state funding from the General Fund. As some of the exchange's functions, such as administering subsidies, are state government responsibilities, general fund contributions are a logical match for these functions. General Fund is a broad based source of funding, and provides no disincentive to carriers or consumers to participate in the exchange. Using General Fund implies finding reductions in other programs or services to offset the additional funding. Further, this could be a less stable financing source that is subject to changes in budgeting priorities.

A final alternative is to include the cost of administering the exchange in the overall cost of reform. This would increase the amount needed to be raised from a payroll, health services transaction, income or other tax used to support the cost of ensuring Oregonians get access to affordable coverage. This mechanism would share the qualities of the overall financing mechanism, including being broad based, equitable, and sustainable. In addition, it does not provide a disincentive for carriers or consumers to participate in the exchange. It is a less transparent source of funding, however, as payers of a payroll or other tax would not be able to readily identify how much of the tax was due to exchange expenses.

The group also discussed utilizing some combination of financing sources, including funds from a premium fee, carrier fee and state General Funds. Further, the group recognized that it may be necessary to fund the start-up of the exchange through a different mechanism than is used to finance its on-going operations.

Other Possible Exchange Participants: Employer Groups

Although the first task of the Work Group was to consider changes to the individual insurance market, Work Group members were very interested in discussing the benefits of an exchange for small employer groups and whether they should be allowed to enroll.

Employees of small employer groups could potentially benefit significantly from an exchange. An exchange could offer choice to a category of consumers who usually do not have carrier choice in their current small group coverage. Added choice increases competition that could lead to lower costs and improved quality in the delivery system and insurance administration. An exchange could also reduce employers' administrative costs by delegating the benefits administration and enrollment functions to the exchange.

Despite these potential benefits, enrolling small groups would involve a number of administrative hurdles and complications. The same risk selection issues that was raised for Category D enrollees (400%+ FPL without employer sponsored coverage) occur for this population, and potentially on a larger scale.

Voluntary Participation. The biggest concern regarding voluntary participation by small groups is adverse risk selection. As individual and group insurance products are governed by different ratings and benefits rules, some groups will find the individual market more appealing, while others will prefer the direct market. For instance, the individual market has a rate band of approximately 5 to 1, meaning that the highest rate can be no more than 5.4 times the lowest rate. The band is 3:1 in the group market. Groups with many older employees may choose to stay in the group market, while those with younger employees may move to the exchange. If many groups make a shift, it could affect overall pricing in the direct group market. It is also possible that high-risk groups would join the exchange, while low-risk groups remain outside the exchange. This is likely as individual market consumers are rated based on age, while the group market rates on a group basis. A costly group may decide to move into the exchange in order to seek lower rates. Mitigating such risks would be difficult, requiring small group and individual rating regulations to be consistent.

Although individual carriers could be protected from disproportionate risk enrollment, if risk selection concerns convince carriers to stop offering coverage either inside the exchange or through the direct market, this could reduce overall consumer choice and impair the functioning of the market.

A Work Group member raised the point that for employers to support reform they must believe that they will benefit from change. Offering services to employers through the exchange could improve small employer support for the overall plan. The group also discussed whether cost or other factors are the most important variables in an employer's decisions regarding coverage.

Some members argued that carriers may not want to support an exchange in a voluntary market. Carriers that currently enroll groups of employees may not want to compete for each of those employees inside the exchange when they previously had the entire group enrolled. This may discourage carriers from offering the exchange their best rates, compared to what they offer in the direct market.

An additional consideration when allowing small employer groups to use the exchange is the difference between rating pools and rating rules in the small group and individual markets. If small groups are allowed in, additional changes would be needed. This could mean a merging of the two markets, with modified rating rules and a combined risk pool across the two markets. Alternatively, groups could be allowed to enter the exchange as a separate group pool, and the two markets could be kept separate, with different rules and risk pools.

Mandatory Small Employer Group Participation. Including all small groups in the exchange would eliminate the danger of adverse risk selection. It would also simplify the entrance process for consumers, providing a single point of entry for all purchasers. It would increase seamlessness, as people who shift between individual and group coverage would not have to change carriers. In addition, it could reduce carriers' administrative costs as the exchange would provide some functions on their behalf.

Requiring all small groups to use the exchange has several disadvantages as well. Depending on the rating regulations, some people could experience significant changes in rates. For example,

the rate for a 60 year old with employer-sponsored coverage is based on the average age of the group. The rate might be quite affordable if the majority of employees are younger. If individual age-rating rules apply in the exchange, however, this person might be subjected to a dramatic rate increase.

This issue could be compounded if the individual and group rating rules are merged. In that case, it is not clear whether the individual market would use the group market's rules, or vice versa. Risk pooling across the two markets could also cause disruption, but at least one member argued that it would likely increase stability due to the large population between the two markets.

If the exchange functions at a strong Tier 2 or Tier 3, some insurers might not be able to meet the standards or would choose to exit the market. To the extent this occurred, it would be more disruptive for current enrollees who would have to switch carriers. While insurers' administrative costs may decline, the cost of administering the exchange would likely offset that reduction to some degree.

If the exchange is the only option for small employer groups and individuals, the exchange would need to offer superior service in order to minimize the complaints that otherwise could arise. Some argue, however, that in a mandatory participation scenario the exchange has a reduced incentive to provide excellent service.

No Small Group Enrollment. Maintaining a separate market for small groups eliminates the danger of adverse risk selection. It would also avoid the potential for "rate shock" for currently insured employees. The major disadvantage of this option is that small employers and their employees would not have access to the benefits of an exchange, such as consumer choice and reduced employer administrative costs. Keeping groups out is also a barrier to seamlessness of coverage. As people move between individual and group coverage, they would move in and out of the exchange, which might require them to change carriers, purchase different benefits, and pay different rates.

Other Groups: Medium and Large Employers

Employees of medium-sized and large employers can not be required to use an exchange due to the ERISA pre-emption of state regulations of health benefits for self-insured employers. In addition, as most large groups offer consumer choice and can more easily absorb the costs of administering health benefit plans, the benefits of an exchange are not as clear for larger groups. Allowing medium and large employer groups the option to participate on a voluntary basis could raise the danger of adverse selection in the exchange, depending on the rating regulations inside the exchange.

Appendix D
Potential Impact on the Small Group Market of Reforming the Individual Market

As discussed in the Recommendations section, the Exchange Work Group agreed that Small Groups not be included in the exchange at this time. The potential benefits of participation in the exchange for small groups and their employees are offset by the regulatory complexity and potential disruptions to rates and coverage. The group suggests the development of a long-range plan that addresses these issues and considers whether and how it might be best to include small groups in the exchange. This may include significant changes in the insurance regulations that apply to the small group market.

During the planning period, however, the small group market may be impacted by the recommended changes to the individual market. The move to guaranteed issue, an individual mandate, and state premium contributions for low-income people – along with continued differences in rating and benefit regulations between the individual and small group markets – are likely to affect small groups, especially micro-groups (those with fewer than 10 employees). It is difficult to predict the impacts, but some possible implications include the following:

Availability of State Premium Contributions for Low-income People Could Lead to Declines in Employer-based Coverage

Some employers currently offering coverage to employees and their dependents will choose to drop coverage if state premium contributions are available for low-income people.
Many employers, especially those with younger employees, may drop employee coverage, making risk pool in the small group market older and more costly. The small group market could decline significantly.

Guaranteed Issue May Result in Declines in Employer-Based Coverage

Some employers currently offer coverage because they know that their employees would have difficulty getting coverage in the individual market. With the elimination of medical screening in the individual market, combined with a merging of the high-risk pool with the rest of the individual market, some employers might drop coverage, knowing employees would be able to obtain coverage in the individual market.

Different Rating Rules between Markets Could Lead to Risk Selection

As discussed in the overview of Oregon's individual and small group markets, the two markets have varying rating rules. In the individual market, rates may vary based on the age of the enrollee. Although there are no regulations regarding the age bands, most insurers use "natural" age rates which result in age bands between 5:1 and 6:1. (In a 5:1 rate band, no enrollee is charged more than 5 times what is charged to the enrollee with the lowest premium.)

In the small group market, rates are set for groups (not individual employees) based on the age composition of the group, and the age bands are limited by regulation to 3:1. While age is the primary factor used to set group rates, other factors, including how long the group has been with the carrier, participation in wellness programs, and expected claims experience (the latter limited to 5% of premium) may also be used. As a result, groups with younger employees may be paying more than they would if the employees went into the individual market. With the move to an individual market with guaranteed issue and state premium contributions for low-income people, the incentive for younger employees to switch to individual coverage will be even stronger.

Summary

The combined effect of these elements will be to draw people from the small group market into the individual market. The individual market will tend to attract lower-income and younger people, some of whom would be considered high-risk. The magnitude of the shift and the net effect on the small group risk pool are difficult to predict, but there could be unintended adverse consequences for the small group market. It would be wise, therefore, to closely monitor the market dynamics and begin planning for changes in market regulation and exchange participation to address these potential problems.

Appendix E
Minority Report from Small Employer, Union, and Consumer Advocates Serving on the Exchange Work Group (6/23/08)

There is much that is positive in the Finance Committee Recommendations regarding reform of the insurance market and functioning of an insurance exchange. As employers and consumer advocates who participated as members of the Exchange Group, we are particularly supportive of the recommendation to require health insurance carriers to issue policies to any Oregonian that seeks coverage, thereby eliminating discrimination against people based on health status and encouraging insurers to compete based on their ability to keep costs down rather than on their ability to market successfully to the best risks. We are also very supportive of the decision to recommend empowering the Insurance Exchange to set performance standards for insurers that wish to sell through the exchange and selectively contract if it appears to be necessary to drive reform of the delivery system. These two recommendations, if adopted, will help set Oregon on the path to achieving its access and affordability objectives for health care reform.

Nevertheless, we believe that more thorough-going reform of the system would make achievement of these objectives more likely. We offer these comments to assist the Board if it believes, as we do, that more aggressive steps will not only improve the program but will also help get it enacted. Our greatest quarrels are with the majority's recommendations to maintain the widely disparate rules for setting premiums in the individual and group markets, to maintain an individual market outside the insurance exchange, and to exclude small groups from participation in the exchange. We are also troubled by the punitive approach taken in the report to the problem of enforcing a requirement that all Oregonians get insurance coverage.

<u>The report fails to recognize the difference between employer-sponsored coverage and individual coverage.</u>

The premise of SB 329 is that Oregon can provide health care coverage to all of its residents either through a combination of employer-sponsored (group) coverage, public coverage (such as OHP), and private individual coverage. The bill and the OHFB committees treat employer-sponsored coverage and individual coverage as if they were interchangeable.

It is true that the interest in getting everyone covered is served regardless of the source of coverage.[16] Unfortunately, however, the cost of coverage to the individual depends on the source of coverage. See box below. These differences create distortions in the market and affect employer and employee choices in troubling ways.

[16] There is one respect in which the Finance Committee has not been indifferent to the difference between employer-sponsored and individual coverage: In its financial modeling, the Committee has assumed that whereas individuals who purchase insurance in the individual market may access income-based subsidies to keep the premium affordable, employees are entitled to no subsidies to keep premiums affordable if their employers pay at least 50% of the premium of the employee and 25% of the premium for dependents. This unfortunate choice was contrary to the Committee's policy preference and was taken solely to reduce the cost of the program—at the expense of equity. It penalizes low-income employees for working for employers that offer coverage and will encourage employers who employ lower-income workers to drop coverage entirely.

Type of coverage	Number of Oregonians with this type of coverage	Effect of age on policyholder cost	Effect of age on individual enrollee costs
Individual coverage	237,000 (including portability and high-risk pool)	Older individuals pay as much as 6x what younger individuals pay.	Enrollee is policyholder so older individuals pay as much as 6x what a younger individuals pay.
Employer-sponsored small group coverage	264,000	Employer premiums are based on experience of all small employers but those with older workforces may pay up to 3x what employers with younger workforces pay.	Enrollees generally pay the same for individual coverage as other employees of the same employer (but sometimes pay more for a richer plan or for dependent coverage)
Employer-sponsored large group coverage	1,572,000 (including self-insured)	Employer premiums are based on the actual experience of the group, so employers with older workforces tend to pay more.	Enrollees generally pay the same for individual coverage as other employees of the same employer (but sometimes pay more for a richer plan or for dependent coverage)

The individual and small group markets should be merged.

In order for a hybrid system to work well, the variation in premiums in the individual and group markets should be reduced if not eliminated so that it does not matter to the individual whether he or she has individual or employer-sponsored coverage. As long as the disparities remain, the design of any universal coverage effort will be driven by efforts to avoid adverse selection as individuals and employers seek to join the market that is most cost-effective for them.

For example, the committee has recommended that small employers not be allowed to purchase through the exchange (at least initially) because allowing small employers to choose between purchasing in the small group market and facilitating individual employee purchase in the individual market will cause "adverse selection." Small groups of younger employees would tend to opt into the exchange due to its individual rating rules whereas groups of older employees would tend to stay out. This selection process would not hurt the exchange; indeed, it would

help keep prices low in the exchange. It would, however, tend to leave the worst risk in the small group market—forcing prices up for the remaining employers.

There are serious costs to the committee's choice to deny small employers the option to purchase through the exchange: First, excluding small employers deprives small employers of the advantages of using the exchange to simplify their benefits administration and give their employees a choice of plans that would not otherwise be available to a small employer. This is particularly important because the Finance Committee is recommending that small employers share in the responsibility for financing the reform package—either by purchasing group coverage or paying a substantial payroll tax. At a time when we will be asking many small employers to take on major new costs, it is very unfortunate that we would not also provide them assistance in meeting their obligations by allowing them to utilize the exchange.

Second, excluding small employers from accessing the exchange undercuts the exchange's ability to help people maintain continuity of plan when they lose their jobs or go to work for another employer.[17]

Third, excluding small employers means the exchange will be smaller and hence less effective at driving delivery system reform.

Fourth, it is not possible to protect the small group market from adverse selection as the majority wishes to do because small employers (particularly those with young, low-paid employees) can achieve many of the advantages of purchasing through the exchange by dropping coverage entirely, raising employee wages, and allowing their employees to purchase through the exchange individually where they can choose among plans and, in addition, access income-based subsidies that the Finance Committee has suggested will be denied to employees with access to employer-sponsored coverage. (See footnote 1.)

Although the majority recognized some of the downsides of barring small employers from purchasing through the exchange, we believe they failed to recommend combining the risk pools and conforming the rating rules because doing so would require raising rates to young, healthy current participants in the individual market. In view of the fact that only 6% of the population is insured in the individual market whereas 16% are uninsured, the committee has unwisely recommended avoiding one-time price increases in the individual market at the expense of reconfiguring the markets in ways that set the stage for price equity and cost containment going forward.

Alternative recommendation:

To avoid the untoward consequences of maintaining many risk pools with different rating rules and denying small employers access to the exchange, we recommend that the individual and small group markets be merged over a brief transition period. Within a discrete period of time, perhaps two or three years, rates would be set based on risk and experience across both markets

[17] This is a major factor, because working age people frequently change jobs and move in and out of Medicaid and private employer-based coverage. See Short and Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," Health Affairs (November/December 2003).

and rate bands would be set to reflect explicit social values. Under the committee recommendation, both the individual and small group markets would be guaranteed issue. The real question is whether rate variation should be permissible based on age in a merged market. If age is not a permissible rating factor, then young people will subsidize older working-age individuals to a substantial degree; this reflects a value of helping those with greater health needs and also helps make individual coverage more similar to large group employer-sponsored coverage. Perhaps, however, some variation ought to be permissible based on age in recognition of the reality that younger workers tend to earn somewhat less than older workers. We recommend, however, that permissible variation be substantially less than in either the individual or the small group markets currently.

<u>The individual market should be subsumed by the exchange.</u>

The committee has recommended that some people be required to purchase through the exchange, some be denied ability to purchase through the exchange, and some be given a choice. We believe the disadvantages of maintaining individual markets both inside and outside the exchange outweigh the advantages of allowing some individuals to purchase outside the exchange.

The committee recommended that individuals who are under 300% FPL but do not have access to employer-sponsored coverage, individuals using pre-tax dollars (section 125 plan dollars) to purchase coverage, and those between 300 and 400% FPL who will access affordability tax credits MUST purchase private insurance through the exchange but that individuals over 400% FPL may choose to purchase through the exchange or in a parallel individual market. This creates unnecessary and costly administration and regulation of the individual market and invites insurers to withhold their commitment to compete with their exchange plans, thereby undermining the success of the exchange at producing high quality and affordable coverage.

Here are some of the problems created by the decision to allow two parallel individual markets, inside and outside the exchange:

- Risk adjustment becomes more complex. The committee recommendation rightly calls for risk adjusting payments so that insurers that attract sicker patients receive higher payments; but by failing to merge the entire individual market, the work group made the task unnecessarily difficult. If all individual policies were sold through the exchange, then the exchange would have the data to perform the risk adjustment function. In addition, because the exchange would be collecting premiums for all carriers, it could easily adjust the amount of premium paid over to each carrier in accordance with the risk adjuster. On the other hand, if, as the committee recommends, individuals can purchase directly from insurers outside the exchange then DCBS will have to collect data on non-exchange individual policyholders for the sole purpose of risk adjustment and will have to find a way to collect dollars from both the exchange and carriers to in order to effectuate the risk adjuster.
- Administrative costs are greater. If insurers can sell in an individual market outside the exchange, insurers will continue to bear marketing and enrollment costs that duplicate costs of the exchange.

- The market is more complex for consumers. If individual consumers can choose to purchase both in and outside the exchange, the exchange function of simplifying and clarifying of options will be less effective.
- The exchange is vulnerable to undermining behavior by carriers. The goal of the exchange is to deliver good quality plans more affordably. The exchange may do this by setting standards and encouraging plans to compete to provide more value for a lower price. If, however, insurers are also selling outside the exchange, they have little incentive to market their most attractive and innovative products through the exchange. Proponents of individual choice to purchase through the exchange or outside the exchange suggest that the choice forces the exchange to prove its value, but if insurers are not dependent on the exchange for their customers then the exchange may not have a chance.
- The exchange is less potent if it is smaller. There are currently about 240,000 people buying individual insurance products. There are about 600,000 individuals who have no insurance. About 350-400,000 of them will not be eligible for public coverage; of those, about 50,000 will be ineligible for subsidies and tax credits. So, depending on whether the exchange includes the non-subsidized individual market as well as the subsidized, the exchange will purchase for anywhere between 300,000 and 640,000 individuals. While the smaller number is ought to be enough to allow the exchange to negotiate good rates with carriers, the larger number would greatly enhance the exchange's power to motivate delivery system change. Indeed, a larger exchange would have more enrollees than Medicare, so that a new exchange-driven reimbursement system might truly change health care in Oregon.

We understand that choice is attractive. However, the design of the exchange anticipates ample options will be available within the exchange.

<u>Making sure everyone is covered</u>

All members of the committee agreed that the goal is for everyone to have health coverage—because coverage promotes access to care and because everyone has responsibility to make a financial contribution by becoming part of the insurance pool. The question is whether we approach the task of achieving universal coverage as problem of compliance or a problem of extending the benefits of coverage to all. Unfortunately, the report casts the health care reform in punitive terms. It recommends *requiring* individuals to enroll in a health plan and *fining* them if they fail to do so. We believe that a successful reform will take a more positive approach. Therefore, we recommend that the state *provide* health plan coverage to everyone and *efficiently collect individual contributions* to paying for the coverage based on ability to pay.

The report states that "participation goals should be met through positive encouragement as well as through penalties on non-participants" (page 12) and suggests that the committee supported penalties as high as 100% of average premium. The report mentions the possibility that all Oregonians might be automatically enrolled in coverage, but states, in summary fashion, that questions were raised about how to identify those who should enroll and how to collect from them. The report fails to offer any useful discussion of automatic enrollment.

There are probably a variety of models for achieving universal enrollment. One that has come to our attention is the Dutch model, which is described in a recent issue of Health Affairs (May/June 08 at page 771ff). Dutch law describes a basic health insurance package. The basic package is offered by a number of private carriers among which everyone can choose. Coverage is offered on a guaranteed issue, community rated basis; 2/3 of the people in the country are entitled to an income-based subsidy from the government. In 2006, 98.5% of the people are enrolled in the basic coverage. The government actively seeks to identify people who are uninsured by matching insurer lists with other government lists. If the uninsured fail to choose a plan after being notified of the opportunity to do so, then they are automatically enrolled in a plan. There has been some difficulty in collecting premiums: 1.5% of the insured population failed to pay premiums in the six-month period before publication of the article.

The Dutch government has the authority to levy a charge of 130% of premium for up to five years for failure to purchase coverage, but the government has chosen to focus on getting people enrolled rather than on collecting penalties. The government plans to begin withholding payments from wages and welfare payments in the same manner as it collects payroll taxes. While the article suggests that the Dutch have yet to solve all of the problems of enrollment and collection, it appears that the problems are both relatively small and relatively tractable.

There is nothing unique about the Dutch experience that suggests that this approach could not be adopted in Oregon. We urge the Board to devote serious attention to how to bring everyone under the tent rather than simply adopting a punitive approach.

Submitted by:

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Appendix F

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

M E M O R A N D U M

April 28, 2008

To: Denise Honzel

From: Cory Streisinger

Copies: Rocky King
Scott Kipper

Subject: Health Insurance Exchange - Employer Health Insurance Issues

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We appreciate the opportunity to comment on the policy issues raised by the Exchange Work Group's discussion of whether small employers should be included (now or in the future) in a health insurance exchange, and we offer these thoughts.

As you know, rating of small employer health insurance in Oregon has recently been changed to include all employers, from 2 to 50 employees, in the same rating pool. Unlike the underwritten individual health insurance market, the small employer health insurance market is guaranteed issue (for employers of two or more); age is the primary rating factor that can be taken into account, though rating can also take into account items such as how long the group has been with the carrier, and participation in wellness programs. Health and claims status may not be taken into account in rating, except up to 5% based on expected claims experience of a small employer. Small employer health insurance is subject to a 3:1 rate band.

We are not addressing your Option (1) (from the work paper dated April 7), since it would not allow small employers in the exchange and thus does not have any bearing on the small employer health insurance market. Our thoughts on the other three options are as follows.

Option (2) – Merge micro groups (2-9 employees) into the individual market; allow them to use the Exchange using individual market rules.

It is true nationally (and true from an actuarial standpoint) that micro-employers of 2-9 employees are more expensive than larger employers because they tend to see a higher incidence of adverse selection — that is, micro-employers with high health care needs are more likely to purchase insurance, especially in the 2-5 employee size group. This is particularly true when the

owner, or a member of the owner's family, has high health care needs. However, in Oregon, because of our rating rules, these micro-employers *do not* pay higher rates than larger employers within the 2-50 market. By law, each carriers' small employer health insurance experience is pooled among all of its small employer health insurance business. Thus, the relatively poor claims experience of the micro-employers is pooled with the relatively stronger experience of the larger employers in the small employer health insurance market. In fact, our recent change in the rating of small employer health insurance, pooling the rating of employers of 2-25 employees with employers employing 26-50, has helped these micro-employers (and reduced their rates or the rate of increases) by giving them a larger and healthier pool with which to share experience.

If the micro-employers were removed from the small-employer health insurance market and pooled separately, or pooled with the individual market, their rates could be expected to rise substantially. If they are pooled separately, this increase would be felt by the micro-employers alone. If they are pooled with the individual market, the increase would be shared by those currently in the individual market. In either event, the costs for the employers of 10-50 employees remaining in the small employer health insurance market could be expected to go down, as they will no longer be in a rating pool with the more expensive micro-employers.

Since a larger rating pool better spreads risk and has better rate stability, we recommend against removing the micro-employers from the small employer health insurance market. These are the smallest businesses for whom insurance costs can hit the hardest, and the businesses who often choose not to provide coverage due to cost. Currently, as part of the small employer health insurance market, they are advantaged by being pooled with larger groups with better experience. Removing them from this pool simply to let them participate in the exchange would be a costly trade-off.

If the exchange were limited to the individual market (Option 1), this would still provide options for these micro-employers if they chose to exit the small employer health insurance market and provide benefits to their employees through a Section 125 plan (assuming the Section 125 research shows this to be permissible). In essence, Option 1 would allow micro-employers to choose group coverage through the existing small employer health insurance market or individual-market exchange coverage through a Section 125 plan.

Option (3) – Allow small groups in the exchange and merge the individual and small group markets.

As noted above, the rating rules for the small employer health insurance market and the individual health insurance market are currently quite different. The small employer health insurance market is subject to a 3:1 rate bands (as opposed to the roughly 5:1 or 6:1 natural rate band in the individual health insurance market). In addition, the use of age as a rating factor is applied to the entire group, not to each individual participant in the group. That is, if an employer group includes a 20-year-old, a 40-year-old and a 60-year-old, all three employees will have the same health insurance premium regardless of their individual ages. This is not true in the individual market, where each individual's age determines their premium.

To make this proposal work, we believe it would require a blending of the entire individual and small employer health insurance markets, for all individual and small employer health insurance purchasers regardless of whether they purchase through the exchange. (If rating rules were different inside and outside the exchange, as you know, we would see significant adverse selection problems.) Blending the individual and small employer health insurance markets, as is recognized in your concept paper, in essence would result in all purchasers purchasing individual products, even if the employer is purchasing them for its employees.

There would be significant rate disruptions. If rate bands similar to the small employer health insurance market were imposed on the individual market, younger and healthier individuals in the individual market would see very substantial price increases. Conversely, if the small employer health insurance market rate bands were eliminated (which moves further from some advocates' policy goal of community rating), all employers would see sizeable price increases for their older workers. Different workers for the same employer would pay different premiums, depending on their age. Your concept paper notes that employers would likely pay the same percentage of premium for each employee, not the same basic dollar amount, but older workers would still end up paying a greater dollar amount to cover their percentage.

A further complication is added by the fact that some benefit mandates in Oregon apply to group health insurance but not individual health insurance. It is not clear at this point whether the benefit committee will recommend inclusion of all existing mandates in the essential benefit package. If all mandated benefits are added to the essential benefit package, the cost implications could be significant. If there continue to be mandated benefits for group health insurance which are not part of the essential benefit package, the discrepancies would have to be resolved in order to blend the individual and small employer health insurance markets.

Option (4) – allow small groups in exchange – establish separate risk pool for small groups (no blended market)

This scenario is feasible, and should not be expected to create significant market disruption. It would provide more opportunity and easier access for small employers, and could reduce administrative cost. However, depending on how issues relating to participation rules are resolved, it may not provide the full benefits anticipated. Under current participation rules, insurance carriers in the small employer health insurance market may require participation rates of 100 percent in order to prevent adverse selection. Stated another way, a carrier providing coverage to a very small employer ordinarily would do so on an exclusive basis only, and would not be willing to cover the employer if employees could choose among several carriers. If these participation rules remain in place, small employers in the exchange would not necessarily see increased choice for employees; the employer might have a broad selection of plans, but the plan selected would then be the only plan available to that employer's employees.

So-called "association" plans do provide an option for some small employers to offer a choice of plans to their employees. However, the rules for "association" plans have been tightly structured to avoid "cherry-picking" of only better risks. For example, qualifying associations must keep high retention rates among their members. Insurance carriers who provide coverage for these "association plans" generally have good information about the composition of the association

and the risks associated with the coverage, and they can price accordingly. If "association plan" type coverage were made available through an insurance exchange, with employees of small employers given a choice of many plans, carriers would need to take this much more open and fluid structure into account in their pricing. The outcome might well be higher and less predictable prices, because carriers would lack the predictable base that allows current "association plan" pricing to be kept in control.

Thus, in considering inclusion of small employers in an exchange, careful thought needs to be given to whether current participation rules would remain in effect. With current participation rules (where very small employers would choose a single plan for all their covered employees), there would likely be little change to the market. Employers, but not individual employees, would have a choice of plans. With a move toward "association plan" rules, in which employees of each employer could select from multiple plans, analysis would be needed to predict how prices would be affected. Price disruptions could potentially be alleviated with a risk adjustment mechanism that would spread the risk of high-cost or high-risk individuals across the carrier's block of business. This would need to be done in a fair and transparent manner. In addition, if the exchange were based on an "association plan" structure, it is not clear how the small employer health insurance market outside the exchange would be affected. If employers do pay a fixed dollar amount toward the premium, further rating uncertainty could be created. Finally, our current small employer health insurance rules require a carrier to pool all of its small employer health insurance risks for pricing purposes. If this remains the same (which would be necessary to avoid adverse selection), the higher prices generated by the risk of lower participation rates could be expected to spread to the small employer health insurance market at large. Again, modeling would be advisable in evaluating these options.

We would be happy to discuss these issues with you in more detail if that would be helpful.