Oregon Health Fund Board

Combining Individual, Portability, OMIP and the Uninsured – early modeling

James Matthisen
The Mosier Group

Data Sources and Assumptions

- Individual Market
  - Size of market from **Covering the Uninsured: The Cost to Oregon**
  - 2007 Carrier filings for 5 large carriers – individual market
  - Generalized to all individual market
  - Assumptions:
    - 85% loss ratio
    - 8% trend
    - 25% average cost sharing

Data Sources and Assumptions

- Portability
  - Size of market from **Covering the Uninsured: The Cost to Oregon**
  - 2007 Carrier filings for 5 large carriers – large group market (baseline cost)
  - OMIP portability data for these assumptions
    - 1.88 allowed charges/premium
    - 1.48 paid claims/premium
  - Other assumptions
    - Admin cost equal to Individual Market
    - 8% trend

Data Sources and Assumptions

- OMIP
  - Size of market from **Covering the Uninsured: The Cost to Oregon**
  - OMIP Stat Pack 2008 and custom data pulls from OMIP staff
  - Other assumptions
    - 8% trend

Data Sources and Assumptions

- Uninsured
  - Number of Uninsured enrolled in combined pool from **Covering the Uninsured: The Cost to Oregon**
  - Assumption Driven Estimate!
    - Per capita ~ 50% of avg cost
    - Unmet demand factor 168%
    - Assumed cost sharing in plan 25%
    - 17% of uninsured joining pool are children
    - 85% loss ratio
    - 8% trend

Qualifiers and Fine Print

- Plan design choices were not modeled
- Please view the results as order-of-magnitude, not best and final estimates
- Input on accuracy of assumptions and data sources is welcome

Summary of Results

	Number of Members	Today's Member Premium PMPM (after implicit portability subsidy and explicit OMIP subsidy)	Pooled Premium All populations (no OMIP subsidy)		Pooled Premium All populations (after OMIP subsidy)	
			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	372	265		249	

Summary of Results
not including OMIP

	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	227	243	

Outline of Draft Exchange Work Group Recommendations Report 8/14/2008

I. Introduction

a. Exchange Work Group's task – develop recommendations regarding:
   i. Changes to the individual (non-group) market within a comprehensive reform plan
   ii. The role a health insurance exchange would play in such an environment

b. Work Group's process

II. Market Reforms

a. Background
   i. Individual market in Oregon
   ii. Problem identification
   iii. Assumptions
   iv. Goals of a reformed individual market

b. Recommendations
   i. Make the Individual Insurance Market a Single Risk Pool
   ii. Establish a Risk Adjustment Mechanism
   iii. Limit Market Disruption from Integration of High Risk Population
   iv. Maintain Current Treatment of Self-employed Sole Employees
   v. Rating Rules Should Support Consumer Information and Access
   vi. Use Essential Services Benefit Definition to Establish Product Baseline and Tiers
   vii. Use a Plan Enrollment Period to Facilitate Universal Coverage and Avoid System Gaming
   viii. Limit Transition Period Disruption for Current Individual Market Enrollees

III. Health Insurance Exchange Options

a. Background
   i. Goals of an Exchange
   ii. Possible functions and roles of an Exchange
      1. Tier 1: Information, Enrollment and Administration
      2. Tier 2: Benchmarking and Standards

3. Tier 3: Rate Negotiation and Selective Contracting
4. Extent to which the tiers meet the goals identified

iii. Participation in the Exchange

1. Impact of including populations in the exchange
2. "Core Populations" – individuals receiving state financial participation
3. Others populations – those without state premium participation
4. Employer groups
5. Pros and Cons of including all populations in the exchange

b. Recommendations

i. Establish Exchange as Strong Tier 2, with Possible Tier 3 Later

ii. Core Populations Required to Use Exchange – Those Accessing State Financial Assistance

iii. Voluntary Participation for Other Individual Insurance Purchasers

iv. Do Not Initially Enroll Groups in Exchange, Revisit Once Individual Exchange is Well Established

IV. Building an Exchange: Administration and Financing

a. Structure of an Exchange

i. Key characteristics

1. Strong accountability and transparency
2. Responsiveness to stakeholders and the public
3. Contracting that happens quickly
4. With a limited appeals process?
5. Process that is open or not?
6. Procurement process that is responsive to the Exchange's timeline
7. Financial accounting and reporting that is rigorous and transparent
8. Personnel policies that facilitate hiring/support for strong employee candidates
9. Salary/wage policies that allow flexibility in compensation to offer industry competitive salaries
10. Independence and statutory decision making authority

ii. Models addressed and examples

1. Public

2. Private
3. Hybrid (several options discussed)

iii. Group discussion (recommendation or general thinking?)

b. Financing the Exchange

i. Goals/Principles

1. Stable, sustainable, and adequate funding source
2. Broad-based, minimizes impact on any single payer
3. No carrier, consumer, employer disincentive for Exchange participation
4. Payer benefits from the Exchange's services

ii. Options and Implications

1. Add to administrative portion of premium for coverage through the Exchange
2. Institute a carrier fee
3. Direct state funding (General Fund)
4. Include in overall cost of reform (add to cost of payroll tax or health services transaction tax)
5. Combination of state General Fund and (1) or (2)

iii. Group discussion (no firm recommendation made)

V. Enforcement of an Individual Insurance Requirement

a. Principles for enforcement

i. Make it easy to administer mandate, comply with it, verify coverage

ii. Stress fairness – people who can afford coverage should buy it, while lower-income people may need assistance to make coverage affordable

iii. 100% compliance will be difficult and expensive; 99% may be enough to reduce the cost shift and minimize adverse selection

iv. A benchmark benefit is defined as meeting coverage requirement

b. Techniques identified for implementing mandate enforcement

i. Significant financial penalty (50% - 100% of average premium cost)

ii. When entering coverage from period of non-coverage, can only purchase minimum benefit for a year

iii. Other enforcement strategies?

c. Issues identified for discussion and further development

(The Work Group did not make recommendations on these issues but identified the need for additional work in the following areas)

i. How limited to comprehensive is the benchmark benefit defined as minimally meeting the coverage requirement?

ii. How does benchmark affect people with access to ESI?

iii. Incentives and penalties are needed – how to balance?

iv. Is compliance monitored via the tax system and/or another mechanism?

v. What entity administers penalties?

vi. How is compliance determined?

vii. How often is compliance determined?

viii. What is the period for having insurance (start or end of year, 12 months)?

ix. What exceptions should be allowed?

x. What would an appeals process look like?

Work Group Assumptions Regarding the "Core" Population in the Exchange

- The exchange's core population is made up of individuals accessing financial assistance:
  - 150-300% FPL via premium assistance
  - 300-400% FPL via affordability tax credits
- To these groups could be added all other workers and dependents of "pay" employers
- Coverage must be affordable and accessible for these populations.
- The exchange is mandatory for these populations, which makes it possible for the exchange to act at Tier 2 or 3 – working with insurers to contract for quality products/good prices for the core population.
- Insurers will want to offer good prices to the exchange in order to enroll people who can only be reached through the exchange.
- The core population will access "mainstream" products (the same products available to unsubsidized individuals using the exchange).

Discussion Item

The Exchange Work Group has expressed support for the following:

- Include "self-pay" individuals above 400% (self-employed or non-employed) in the exchange on a voluntary basis.
- Utilize one cohesive risk-spreading pool for all enrollees in the individual market, with rates based on each carrier's medical experience for all enrollees. The medical component of rates would be the same for the same product offered inside and outside the exchange.
- Allow the exchange to function at Tier 2 or 3 (set standards for carrier participation and/or negotiate with carriers regarding standards for participation).

But: allowing unsubsidized individuals to voluntarily enter the exchange causes technical problems for an exchange expected to function at Tier 2 or 3.

- In order for the exchange to succeed with voluntary entry, rates must be the same inside and outside the exchange. Otherwise, adverse selection will very likely occur.
- However, to function most effectively at Tier 2 or 3, the exchange would need the flexibility to negotiate different rates.
- The state, like a very large employer, has purchasing clout because it requires people to obtain coverage through the applicable program. This gives the state "cohesion". Insurers contract with the State in order to reach a large enrollee population that cannot otherwise be reached. Such purchasing power can not be achieved merely by having the exchange declare itself a purchasing venue for individuals and small groups that can still contract directly with an insurers.
- In a voluntary market, the exchange has reduced clout. Insurers may not want to offer a reduced administrative rate component to the exchange for people they already enroll

directly in the market. Insurers also do not have an incentive to establish cost containment strategies that would reduce costs within the exchange. If the exchange wanted to innovate on the medical delivery component, would insurers want to participate in such efforts?

- Higher prices for the non-subsidized population, if applicable to the core exchange population, will increase state subsidy costs. However, separating subsidized and unsubsidized populations into two risk pools could lead to overall higher premiums for subsidized individuals, depending on the risk profiles of the various groups.
- The only ways for the exchange to have clout on cost management are: (1) for the exchange to have a separate risk pool for the subsidized group or (2) by having the exchange drive the market with changes in the subsidized arena that then affected the rest of the individual market, to the benefit of the direct market consumer.
- If the "core" population for the exchange was much bigger than the individual and small employer markets, the impact of a voluntary market would not be so problematic. Initial estimates of the various populations involved do not suggest that the subsidized population is large enough to outweigh the effect of voluntary unsubsidized individual and small employer markets.
- One option is for the exchange to run two separate programs: one for individuals accessing subsidies and other financial assistance (tax credits, 125 plan funds); the other for unsubsidized individuals and small employer groups. The subsidized population in this first group is mandated to use the exchange, which gives the exchange the power to negotiate on their behalf. For the voluntary, unsubsidized population, the exchange will act mostly in a "tier 1" capacity.

Options

Option	Population	Voluntary/ Mandatory	Exchange Operates at What Tier	Considerations
A	150-400% FPL	Mandatory	Tier 1	Unlikely to drive value in the system
	400%+ FPL	Voluntary	Tier 1	
B	150-400% FPL	Mandatory	Tier 2-3	If Tier 2-3 for subsidized population and Tier 1 for others, could have separate "doors" with separate product offerings (like MA's Commonwealth Care vs. Choice).
	400%+ FPL	Voluntary	Tier 1 or 2-3	
C	150-400% FPL	Mandatory	Tier 2-3	Would exclude a population that the work group would like included.
	400%+ FPL	Excluded	Not Applicable	
D	150-400% FPL	Mandatory	Tier 2 – 3	Reduces choice for 400%+ FPL population, lets exchange negotiate on behalf of whole population
	400%+ FPL	Mandatory	Tier 2 – 3	

Introduction

Looking at which populations should be included in the exchange, the work group has focused primarily on different categories of individuals. However, those in small groups could potentially benefit most from an exchange. Consumers could have increased choice, reduced costs, and improved delivery system and insurance administration quality. Employers could see reduced administrative costs. There are complications regarding the use of the exchange by small groups.

The biggest concern regarding optional participation by small groups in the exchange is adverse risk selection, the possibility that high-risk groups would disproportionately either join the exchange or remain outside the exchange. Which direction high risk groups went depends on two major factors which the incentives for one potentially working in the opposite direction from the other.

On one hand, if the exchange uses the age bands established for the individual market and groups can voluntarily choose to remain in the small group market using group rules and rates, employer groups with younger employees would tend to migrate to the exchange. The group insurance market has fewer age bands than exist in the individual market. This makes individual insurance cheaper for younger enrollees, but more expensive for older ones. Group coverage tends to be relatively more expensive for younger enrollees, but a better "deal" for older enrollees. The movement of younger people from the regular group market into the exchange would tend to reduce overall rates for exchange members and increase rates for remaining group market enrollees.

However, employer groups with high-risk people (e.g., diabetics, people with heart disease, cancer patients) would tend to join the exchange, as small group rates can now be adjusted for group experience (+/- 5%), per the 2007 legislative changes. Mitigating this risk would be difficult, as it would require small group and individual rating regulations be made consistent. This would require the creation of a complex risk adjustment mechanism, and/or require all segments to use the exchange.

Options

(1) Do Not Allow Groups Into the Exchange

In this scenario, only individual market purchasers can enter the exchange. Employees of small groups (2-50) that offer coverage will get insurance as they do now, via the direct small group market.

Pros

- Simple
- Minimal disruption to existing small group market

Cons

- Does not offer the benefits an exchange can provide to employees and employers of small groups, such as:
    - Individual choice of plan
    - Employer access to HR functions

(2) Merge Micro Groups (2-9 employees) into the individual market; allow them to use the Exchange (Using Individual Market Rules)

In this scenario, all individuals and employees of micro groups (firms with 2-9 employees) will be subject to individual market rules and will purchase individual products. Employees of other small employers (groups of 10-50) purchase group products at group market rates.

Pros

- MEPS data show that insurance premiums for micro groups (2-9) are more costly than premiums for groups of 10 and above. This suggests that micro groups currently do not benefit from lower administrative cost for groups and/or that a number of younger and healthier micro groups have converted to individual coverage to save money (leaving expensive micro groups that drive up average group market prices).
- Employers of micro groups are the least likely to offer ESI and are more likely to employ low wage workers. Many employees of micro groups will be eligible for state premium participation or tax credit. Access to the exchange will improve continuity of coverage for these individuals.
- When employers of micro groups do provide ESI, they are the least likely to offer choice of plans. Allowing micro groups into the exchange provides choice to employee groups with least current access to choice.
- The administrative burden on employers offering ESI is greatest for micro groups. Participation in an exchange would provide the greatest benefit to such employers.

Cons

- This could cause disruption for a portion of the small group market, as it would create a new category and change rating and benefits rules for groups of 2-9.

Other Issues

- Question – are micro groups mandated to enter the exchange or allowed in on a voluntary basis?
- Question – are small groups (10-50) allowed into the exchange? On what basis (mandatory or voluntary)? Would such groups use group or individual rating?
- Requires statutory change to allow employers to pay for individual insurance products for employees and their dependents.

(3) Allow Small Groups in Exchange and Merge the Individual and Small Group Markets

In this scenario, all individuals and small groups (2-50 employees) purchase insurance under the same market rules. Rating and benefit regulations are aligned for both the individual and small group markets.

Pros

- Increased choice for employees of small employers.
- Could reduce small employers' HR-related costs.
- Avoids employer incentive to choose between group and individual market based on employee age profiles.
- Less fragmented market.

Cons

- Can cause disruption to the individual and/or small group markets, as rating and benefits rules would be aligned for all individual and group purchasers.
- Having dual group markets (inside and outside the exchange) adds administrative complexity.

Other Issues

- Essentially makes groups purchase individual products for each employee.
- Underlying cost for a two person group would be the same within the "individual" and "group" markets.
- Would require a law change, currently employer can not fund individual insurance for employees.
- Employer could pay the same percentage of premium for each employee (not same $ total).

- Could do risk adjustment based on carrier-product pairs (similar to how an all individual market risk adjuster would work).
- Are small groups (2-50) allowed into the exchange on a voluntary basis or mandated to enter?

(4) Allow Small Groups in Exchange – Establish Separate Risk Pool for Small Groups (no blended market)

In this scenario, small groups (2-50) purchase group products at group market rates, but each employee retains a choice of plans. Assumes defined contribution by employer, which allows employee to shop for products and use employer contribution to purchase preferred plan.

Pros

- Increased choice for employees of small employers.
- Could reduce small employers' HR-related costs.
- May avoid risk selection problems, market disruption described in (3).
- Keeps employer contributions in the system, while facilitating access to state premium assistance or tax credits for eligible employees (minimizes state contribution while maximizing assistance to individual).
- Risk selection can be minimized if:
    - The exchange has the same minimum contribution and participation rate requirements as the outside small group market; and
    - The exchange offered the same group plans as are available in the outside market.
- Allowing employer to benchmark a contribution based on a particular plan does not require employer to retain a given carrier if its premiums rise over time. Employer may switch benchmark carrier or allow Exchange to benchmark to lowest cost carrier.

Cons

- Carriers may object to having to compete on an individual basis for enrollees currently in their products as small groups.
- Having dual group markets adds administrative complexity

Other Issues

- This scenario assumes that risk in the small group market is pooled for a carrier across all small group market enrollees. This includes exchange-based enrollees and traditional small employer groups. Employees of firm X would be considered members of the plan in which they were enrolled, and all enrollees in carrier A would be combined for the purposes of rating within that plan. If two of firm X's employees were in Exchange-based coverage through carrier A, they would be combined with all of firm Y's employees, who purchase through carrier A as a traditional group.
- An employer that allows employees to enter the exchange with employer provided funds would be a "play" employer for the purposes of a payroll tax with a "play" credit. An employer that allows employees to enter the exchange but provides no dollars is a "pay" employer.
- May require a law change to identify exchange-offered group market products as "group" coverage.

Organizational Structure and Governance of an Exchange

The Exchange Work Group has identified that the following are key characteristics of an exchange's governance structure:

- Strong accountability and transparency
- Responsiveness to stakeholders and the public
- Contracting that happens quickly
    - With a limited appeals process?
    - Process that is open or not?
- Procurement process that is quick and responsive to the Exchange's timeline
- Financial accounting and reporting that is rigorous and transparent
- Personnel relations that facilitate the hiring of and support for strong employee candidates
- Salary/wage policies that allow flexibility in compensation to offer industry competitive salaries
- Independence and statutory decision making authority

Areas in which a public entity could need flexibility similar to that of a private sector entity:

- Contracting
- Procurement
- Financial accounting and reporting
- Personnel relations
- Salary/wage policy

State statute can direct the Exchange's Board to adopt policies and procedures for:

- Appeal of contracting decisions
- Appeal by individuals affected by decisions of the exchange or contractors operating on behalf of the exchange
- Public meetings generally, with exceptions for sensitive matters
- Regular financial and operational reports from the Board to the Legislature and the public (but in a form similar to private financial reporting, not public agency reporting)

Public Organizations Chartered to Balance Accountability and Flexibility

1. ORS 656.751 defines Oregon's State Accident Insurance Fund Corporation (SAIF) as a public corporation.[1]

   - SAIF is an independent public corporation governed by a board of five directors appointed by the Governor.
   - Two board members represent the public.
   - Of the remaining three board members, one member must be insured by SAIF at the time of appointment and for one year prior to appointment, or be an employee of such an employer.
   - Members of the board are subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution.
   - ORS 656.753 Exempts SAIF from state statutes regarding:
     - Personnel relations
     - Facilities
     - Contracting and insurance
     - Contracting and procurement
     - Interagency services
     - Printing
     - Public finance administration
     - Salaries
     - Administration of public funds

[1] Except as otherwise provided by law, the provisions of ORS 279.835 to 279.855 and ORS chapters 240, 276, 279A, 279B, 279C, 282, 283, 291, 292 and 293 do not apply to SAIF.

2. The Massachusetts Health Insurance Connector Authority is established as a "body politic and corporate and a public instrumentality…which shall be **an independent public entity**. "

- The Connector is not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the Commonwealth except as specifically provided in any general or special law.

- The Connector is governed by a Board consisting of 11 members:
    - A salaried Executive Director appointed by the Chair of the Board
    - The Secretary for Administration and Finance, ex officio, serves as chairperson
    - The Director of Medicaid, ex officio
    - The Commissioner of Insurance, ex officio
    - The Executive Director of the Group Insurance Commission
    - 3 members appointed by the governor
        - An actuary
        - A health economist
        - A small business representative
    - 3 members appointed by the Attorney General
        - An employee health benefits plan specialist
        - A representative of a health consumer organization
        - A representative of organized labor

    - The Connector Board implements the Commonwealth Health Insurance Connector.
    - The goal of the Board is to facilitate the purchase of health care insurance products through the Connector at an affordable price by eligible individuals, groups and Commonwealth Care enrollees.
    - The Board's powers include but are not limited to:
        - Develop a plan of operation for the Connector.
        - Determine applicants' eligibility for purchasing through the Connector and receiving subsidies.
        - Seek and receive funding.
        - Contract with professional service firms and to fix their compensation.
        - Charge and equitably apportion among participating institutions its administrative costs and expenses.
        - Enter into interdepartmental agreements with the Department of Revenue, the Executive Office of Health and Human Services, the Division of Insurance and any other state agencies.

3. The Energy Trust of Oregon, Inc. is a nonprofit corporation subject to the requirements of the Internal Revenue Code section 501(c)(3).

   - The Corporation has and may exercise all the rights and powers of a nonprofit corporation under the Oregon Nonprofit Corporation Act.
     - Purpose: The Energy Trust supports the development of cost-effective local energy conservation, market transformation energy conservation, and renewable energy resources for certain utility customers in Oregon.
     - Its funding comes from a 3% "public purposes charge", channeled to the Energy Trust via the Oregon Public Utility Commission (OPUC).
   - The Energy Trust's Board of Directors:
     - Manages the business and affairs of the Corporation and exercises or directs the exercise of all corporate powers.
     - Is made up of 5-12 voting directors, the exact number to be fixed from time to time by resolution of the board of directors. One "ex officio", non-voting member of the board of directors is appointed by the Oregon Public Utility Commission.
   - Officers of the Corporation are elected by the Board include a President, one or more Vice Presidents, a Secretary, a Treasurer, an Executive Director and a Chief Financial Officer.

4. The Land Conservation and Development Commission was established by ORS 197.030.

   - The seven Commissioners are unpaid citizen volunteers appointed by the Governor and confirmed by the Senate.
     - The statute establishing the Commission directs that the members represent certain regions of the state, and include a current or former elected official of a city and a county.
   - LCDC is required by statute to adopt "statewide land use policies," including statewide goals and administrative rules, "necessary to carry out ORS chapters 195, 196 and 197" (Oregon's statewide land use planning program).
   - Powers of the Commission include:
     - Applying for and receiving moneys from the federal government and from this state or any of its agencies or departments.
     - Contracting with any public agency for the performance of services or the exchange of employees or services by one to the other.
     - Contracting for the services of and consultation with professional persons or organizations, not otherwise available through federal, state and local governmental agencies.

5. The Environmental Quality Commission (EQC) is a governor-appointed citizen panel.
    - The Commission serves as the Department of Environmental Quality's policy and rulemaking board.
    - The Commission consists of five members, appointed by the Governor, subject to confirmation by the Senate.[2]
    - EQC Responsibilities
        - The EQC adopts rules and standards as it considers necessary and proper to carry out statutory direction. [ORS 468.020]
        - Most implementing actions are carried out by the Department pursuant to statute and implementing rules (i.e. issuance of most permits, approval of plans, issuance of civil penalties, etc.).
            - As provided by specific statutes and EQC rules, decisions of the DEQ Director may be appealed to the EQC pursuant to the provisions of the Administrative Procedures Ace (ORS Chapter 183) for contested cases.
            - In selected instances, statutes specify that the Commission, rather than the Department, is the administrative decision-maker (i.e. issuance of a license for a hazardous waste disposal site).

[2] As provided in ORS 171.562 and 171.565. [ORS 468.010(1)].

6. Legislation is pending in Minnesota to create an exchange as a public, 501(c)(3) not-for-profit.

- The Minnesota Health Insurance Exchange shall be formed as a nonprofit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.[3]
- The entity is statutorily chartered but not an agency of state government.
- Exchange functions: the exchange may serve as a coordinating entity for enrollment and collection and transfer of premium payments for health plans sold to individuals through the exchange
- Exchange powers:
  - Contract with insurance producers licensed in accident and health insurance under chapter 60K and vendors to perform one or more of the functions of the exchange.
  - Contract with employers to collect premiums for small employer plans and for individual market health plans purchased through a Section 125 Plan.
  - Establish and assess fees on health plan premiums of small employer plans and individual market health plans to fund the cost of administering the exchange.
  - Seek and directly receive grant funding from government agencies or private philanthropic organizations to defray the costs of operating the exchange.
  - Establish and administer rules and procedures governing the operations of the exchange.
  - Establish one or more service centers within Minnesota.
  - Sue or be sued or otherwise take any necessary or proper legal action.
  - Establish bank accounts and borrow money.
  - Enter into agreements with the commissioners of commerce, health, human services, revenue, employment and economic development, and other state agencies as necessary for the exchange to implement its functions.
- The board is made up of 11 members.
- Initial membership includes:
  - The commissioner of commerce
  - The commissioner of human services
  - The commissioner of health
  - Eight public members with knowledge and experience related to health insurance and health insurance markets, appointed to serve three-year terms expiring June 30, 2011.
    - Two members appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate
    - Two members appointed by the speaker of the house of representatives
    - Four members appointed by the governor

[3] Sec. 14. [62U.02] Minnesota Health Insurance Exchange. Article 4 Sec. 14. 42 Subd (2).

- Ongoing membership (as of July 1, 2011) includes:
  - The commissioner of commerce
  - The commissioner of human services
  - The commissioner of health
  - Two public members appointed to serve two-year terms
    - One member appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate
    - One member appointed by the speaker of the house of representatives
  - Four public members elected by the membership of the exchange (two will serve a two year term, two will serve a three year term)
- Elected members may serve more than one term.
- At least one of the elected members must represent a small employer, and at least one member will be a person who purchases an individual market health plan through the exchange.

POSSIBLE FINANCING MECHANISMS FOR THE EXCHANGE

GOALS/PRINCIPLES

Funding source(s) should:

1. Provide stable, sustainable, and adequate funding for Exchange's work.
2. Be broad-based and minimize impact on any single payer.
3. Not act as a disincentive for carriers, consumers, or employer groups to participate in Exchange.
4. Payer should benefit from the services.

OPTIONS

1. Incorporate in the administrative component of premium for coverage through the Exchange.
2. Institute a carrier fee (could be individual market covered lives only, on individual and group lives or on all insurers and reinsurers).
3. Direct state funding (General Fund).
4. Direct state funding (include in overall cost of reform, i.e. funding could be from a payroll tax or health services transaction tax).
5. Combination of state General Fund and (1) or (2) above.

PROS AND CONS

1. Incorporate in the administrative component of premium for Exchange-based coverage
   - **Pros** Those pay the fee directly benefit from the services
     Gives incentive for Exchange to have an efficient administrative structure
   - **Cons** While the medical components of the rates in and outside the exchange, the administrative load inside may be more than it would be outside the Exchange, thus making the Exchange products more costly.
     Less broad-based; burden falls primarily on the insurers, groups, and consumers that participate in the Exchange.

2. Institute a carrier fee on covered lives
   - **Pros** Spreads the cost most broadly.
   - **Cons** Those not using the Exchange still have to pay the fee.

3. Direct state general fund contribution
   - **Pros** Some of the functions of the Exchange (e.g. administration of subsidies) are the responsibility of the State; general fund contributions would seem most logical for these functions.
     Very broad based source of funding.
     There is no disincentive for carriers, consumers, or employer groups to participate in the Exchange.
   - **Cons** Potentially a less stable financing source, subject to biennial budget allocation changes.

4. Direct state contribution from overall reform financing (e.g. payroll or health services transaction tax)
   - **Pros** Will have all the qualities of the overall financing mechanism, including being broad based, equitable, and sustainable.
     No disincentive for carriers, consumers, or employer groups to participate in the Exchange.
   - **Cons** Funding source is less transparent since not broken out of overall financing mechanism.

Note: 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.

Possible Financing Mechanisms Based on Function of the Exchange

	Include in Admin. Rates	Fee on All Covered Lives	Direct State Funding
Tier 1 Functions			
Information, customer service, and enrollment	X	X	
Administration of state premium contributions			X
Aggregate premiums from multiple sources	X	X	
Administer Section 125 plans	X		X
Implement risk adjustment mechanism		X	X
Train agents and brokers on Exchange		X	X
Tier 2 Functions			
Establish standardized or comparable benefits	X	X	X
Establish performance benchmarks	X	X	X
Contract for services	X	X	X
Establish agent/broker role in distribution and marketing	X	X	
Tier 3 Functions			
Solicit bids	X	X	X
Negotiate prices	X	X	X
Select carriers	X	X	X

Health Insurance Exchange Options

ISSUE ONE: Who Uses the Exchange?

Categories of participants that could benefit by using an exchange:

A. Individuals receiving state premium contributions (income between 150-300% FPL)
B. Individuals receiving tax credits for premium purchase (income between 300-400% FPL)
C. Individuals not eligible for employer's ESI, but who can use Sect. 125 plan (income above 400% FPL)
D. Individuals working for non-offering employer, who use Section 125 plan (income above 400% FPL)
E. Self-employed or non-employed individuals with income above 400% FPL
F. Employees of small employer groups
G. Employees of medium and large employer groups

Categories A, B and C are the core of an insurance exchange.

Category D individuals (working for non-offering employers) work for the smallest employers and are most likely to be eligible for state premium assistance or tax credits. The exchange will provide continuity of coverage and care as people move in and out of eligibility for premium assistance or tax credits.

Category E (self-employed or non-employed individuals with income above 400% FPL), could be treated in one of three ways:

1. **Include them** in the exchange (all individual coverage provided through the exchange)
2. **Allow option** of participating in the exchange or purchasing coverage outside the exchange (dual market with a "permeable wall")
3. **Do not allow them to participate** in the exchange (dual market with an "impermeable wall")

Category F (small employers groups) is the population that could benefit the most from an exchange. Consumers could benefit from increased choice, reduced costs, and improved delivery system and insurance administration quality. Employers could see reduced administrative costs. The options for small employer groups are:

1. **Include them** in the exchange (consolidate the individual and small group markets)
2. **Allow participation** in the exchange or purchase outside the exchange (dual small group market with a "permeable wall")
3. **Do not allow participation** in the exchange (keep the small group market separate from the individual market)

The biggest concern regarding optional participation by small groups in the exchange (option 2) is **adverse risk selection**, i.e., the possibility that high-risk groups would join the exchange, while low-risk groups remain outside the exchange. This danger with small groups is even greater than with self-pay individuals, since small groups are rated on a group basis while individuals are rated on an age-basis. Mitigating this risk would be more difficult, since it would require small group and individual rating regulations to be consistent.

In addition, there are different rating pools and rating rules between the small group and individual market. If small groups were to be included, there would need to be additional changes such as modifying the rating rules (same rate bands in both markets) and combining the two risk pools.

Category G (medium and large employers) can not be required to use the exchange due to ERISA's pre-emption of state regulations of health benefits for self-insured employers. The benefits of an exchange are less than for small groups, as most larger groups now offer consumer choice and can more easily absorb the cost of administering health benefit plans. Allowing them the option to participate may raise the danger of adverse selection in the exchange, depending on the rating regulations in the exchange.

ISSUE TWO: What Could an Exchange do for Oregonians?

An insurance exchange can play a relatively narrow role with a limited set of functions, to a broader role with more functions. It could provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

1. Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices
- Design decision support tools and provide cost, quality and service transparent information
- Manage open enrollment process with efficient, user-friendly health plan enrollment
- Establish an eligibility confirmation and state premium contribution administration process
- Help employers and others to set up and administer Section 125
- Provide a mechanism to collect and aggregate premium contributions from multiple sources
- Ensure provision of customer services, (provide and coordinating with brokers and carriers)
- Administer risk adjustment mechanism to protect insurers who enroll high-risk members
- Train agents and brokers on exchange functions; connect people with educated agents, brokers

2. Benchmarking and Standards

- All of the functions above, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes
- Allow contracting for full packages of products and services from the carriers, or contracting separately for benefits or services that might better achieve benchmark performance
- Establish agent and broker role in distribution and marketing of plans offered in the exchange.

All carriers that meet the benchmark standards would contract with the exchange to offer coverage through the exchange.
Note: this category should be viewed as a continuum, depending on how performance benchmarks are set. If the standards were set relatively low, there would be more carriers participating, and the exchange would be operating similar to tier 1. If the standards were set relatively high, however, there would be fewer carriers, and this would begin to look more like tier 3, described below.

3. Rate Negotiation and Selective Contracting

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

Health Insurance Exchange Options

The following is a list of possible goals for a health insurance exchange:

- **Help Consumers Shop for Insurance**: by providing consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.
- **Make it Easy for Consumers to Enroll**: by providing an efficient and user-friendly mechanism for enrollment in health plans.
- **Help Consumers and Insurers with Payment Processing**: by providing a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.
- **Help Consumers by Offering Customer Service**: by providing information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.
- **Encourage Carriers to Participate in the Exchange:** by streamlining the marketing and enrollment functions, and by protecting carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.
- **Make it Easy for Consumers to Compare Options:** by standardizing or categorizing benefit plans offered by carriers.
- **Offer Choice to Consumers:** by ensuring that consumers have a choice of multiple carriers, providers and delivery systems.
- **Lower Costs and Improve Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System:** for example, by establishing standards for carrier participation, evaluating carriers and their provider networks, encouraging innovations in provider payment, encouraging healthy competition based on quality and efficiency
- **Lower Costs and Improve Quality for Consumers by Encouraging Innovation and Improvements in Insurance Administration:** for example, through incentives for efficient administration and effective customer service.
- **Maximize benefit of government contributions to low-income people:** by ensuring that taxpayer dollars are deployed to obtain the best value.
- **Minimize the disruption** for current (mostly self-pay) consumers in the individual market.
- **Encourage participation of carriers** in the individual market generally, regardless of the presence and role of an exchange.
- Make it easy for consumers to move between subsidized and non-subsidized individual coverage, as well as between individual and small group coverage, i.e., **"seamlessness"**.
- Facilitate the task of **managing risk selection** to avoid an adverse risk spiral in any market segment.

Assumptions: In the discussion below of the key issues related to the design of an insurance exchange, the following reform elements are assumed:

- Reforms to the individual market, including, guaranteed issue, elimination of the current high risk pool, and a new mechanism to address the costs for high-risk persons
- A requirement for all Oregonians to have health insurance
- A government premium contribution for low income people (150-300% FPL) to partially cover the cost of coverage, and tax credits for low-middle income people (300-400% FPL).
- A requirement that all employers offer a Sec. 125 plan for employees so that employees can receive the exemption from taxable income for health insurance premium payments.

Issue 1: Who may or must purchase through the exchange?

Categories of participants that could benefit by using an exchange:

A. Individuals receiving state premium contributions (income between 150-300% FPL)

B. Individuals receiving tax credits for premium purchase (income between 300-400% FPL)

C. Individuals not eligible for employer's ESI, but who can use Sect. 125 plan (income above 400% FPL)

D. Individuals working for non-offering employer, who use Section 125 plan (income above 400% FPL)

E. Self-employed or non-employed individuals with income above 400% FPL

F. Employees of small employer groups

G. Employees of medium and large employer groups

Impact of Increasing the Size of the Exchange

The goals of **Consumer Shopping, Enrollment, Payment Processing,** and **Customer Service** would be met for everyone participating in the exchange. Increasing the size of the exchange (i.e., including more categories) would simply offer these services to more people.

Other advantages and disadvantages of increasing the size of the exchange include:

- A larger pool would *spread any 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 [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
- A larger pool would *spread the risk more broadly*, provide more stability for the pool over time, and potentially lessen the danger of an adverse risk spiral. As with spreading fixed administrative costs, the benefit of this is significant up to a certain level [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
- If the goals of **Lowering Costs and Improving Quality** are considered important, a larger exchange could have more influence in the market – especially if the exchange worked closely with other large public and private purchasers. (This would also depend on the role that the exchange chooses, especially if it set high performance benchmarks for carrier participation in the exchange, i.e., the "upper" end of Tier 2 functions).

Including additional categories of people raises issues, however, that may offset the general advantages of increasing size. The pros and cons of including each category are described below.

Categories A, B and C are the core of an insurance exchange. Most of these people are currently uninsured; the exchange would offer services to help them purchase coverage. If the exchange operates at level 2 or 3, this would help to meet the goal of **maximizing the value of government contributions** (including premium contributions, tax credits and taxable income exclusions).

Individuals in Category D (those who work for a non-offering employer) tend to work for so-called "micro-employers" with only a few employees. One reason to require all such employees to enter the exchange is that this is a category of employees that tend to move between subsidized and unsubsidized coverage. Approximately 70% of individuals employed by non-offering employers are subsidy eligible. Of the remaining 30%, some will be eligible for a tax credit; the rest fit into Category D. Requiring that such individuals access coverage through 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.

For Category E (self-employed or non-employed individuals with income above 400% FPL), there are three options:

1. **Include them** in the exchange (thereby consolidating the individual market)
2. **Allowing participation** in the exchange or purchase outside the exchange (thereby creating a dual market with a "permeable wall")
3. **Do not allow them to participate** in the exchange (thereby creating a dual market with an "impermeable wall")

Summary of Options for Category E – self-employed & non-employed above 400% FPL	**Pros**	**Cons**
1. Include in exchange (consolidated market)	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. Optional participation (dual market with "permeable wall")	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
3. Non-participation (dual market with "impermeable wall")	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

The biggest concern regarding optional participation in the exchange (option 2) is **adverse risk selection**, i.e., the possibility that high-risk individuals would join the exchange, while low-risk individuals remain outside the exchange. This would lead to an adverse selection spiral within the exchange; historically, this has occurred frequently with exchanges in other states.

The problem of risk selection can be mitigated – at least to some degree – by the following:

- Application of the same insurance regulations (e.g., guaranteed issue, rating, benefit design, etc.) inside and outside the exchange. [Note: the rating methodology would need to be the same, but the rates themselves would not have to be identical, e.g., there might be different administrative loading factors inside and outside of the exchange.]
- Use of a risk adjustment mechanism between the two segments (within the exchange vs. outside of the exchange)

The consensus of insurance experts is that these steps would reduce the danger of adverse risk selection, but it would require significant regulatory and administrative efforts to accomplish this.

Including all individuals in the exchange (option 1) would eliminate the danger of adverse risk selection. It would also simplify the entrance process for consumers ("one door"), reduce carriers' administrative costs, and increase "seamlessness" i.e., people who shift from subsidized to unsubsidized would not have to change carriers.

The disadvantages of requiring all individuals to use the exchange include:

- If the exchange assumes Tier 2 or 3 functions, 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 might have to switch to a different insurer.
- While insurers' administrative costs may decline, the cost of administering the exchange would likely offset that reduction to some degree.

Creating a dual market with an "impermeable wall" (option 3) also eliminates the danger of adverse risk selection. It would also minimize disruption for currently insured self-pay individuals, since they could stay with their current carrier. The major disadvantage of this option is that it might reduce "seamlessness". As people move between unsubsidized and subsidized coverage, they would move in and out of the exchange, which might require them to change carriers.

Other considerations:

- Self- and non-employed individuals would not benefit as greatly from the administrative efficiencies and choice of insurers provided by the exchange as others would, such as small employer groups.
- If there is no alternative to using the exchange, it will be necessary for the exchange to offer superior service in order to minimize the complaints that are likely to accompany this scenario.

In many ways, Category F (small employers groups) could benefit the most from an exchange:

- It would **offer choice to consumers**, most of whom do not have a choice of carrier in their current small group coverage. This might have a secondary effect on **lowering costs and improving quality** in the delivery system and insurance administration.
- It would **reduce employers' administrative costs** by delegating the benefits administration and enrollment functions to the exchange.

For Category F there are three options:

1. **Include them** in the exchange (consolidate the individual and small group markets)
2. **Allow participation** in the exchange or purchase outside the exchange (dual small group market with a "permeable wall")
3. **Do not allow participation** in the exchange (keep the small group market separate from the individual market)

Summary of Options for Category F – Small employers and their employees	*Pros*	*Cons*
1. Include in 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	Potential for "rate shock" for older persons. 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) Could require alignment of rating rules between individual and small group markets; combination of individual and small group market risk pools
2. Optional participation (dual market with "permeable wall")	Possibly increased choice	Significant danger of adverse risk selection in the exchange Could require alignment of rating rules between individual and small group markets; combination of individual and small group market risk pools
3. Non-participation (small group market separate from individual market)	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 Less seamlessness – people moving between individual & group coverage may have to change carriers

The biggest concern regarding optional participation by small groups in the exchange (option 2) is **adverse risk selection**, i.e., the possibility that high-risk groups would join the exchange, while low-risk groups remain outside the exchange. This danger with small groups is even greater than with self-pay individuals, since small groups are rated on a group basis while individuals are rated on an age-basis. Mitigating this risk would be more difficult, since it would require small group and individual rating regulations to be consistent.

Including all small groups in the exchange (option 1) would eliminate the danger of adverse risk selection. It would also simplify the entrance process for consumers ("one door"), reduce carriers' administrative costs, and increase "seamlessness" i.e., people who shift between individual and group coverage would not have to change carriers.

The disadvantages of requiring all small groups to use the exchange include:

- Depending on the rating regulations, some people might experience significant changes in their rates. For example, the current rate for a 60 year old small group employee is based on the group demographics, and the rate might be quite affordable if the other employees are in younger age categories. If individual age-rating rules apply in the exchange, however, this person might be subjected to a **dramatic rate increase**.
- If the exchange assumes Tier 2 or 3 functions, 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 might have to switch to a different insurer.
- While insurers' administrative costs may decline, the cost of administering the exchange would likely offset that reduction to some degree.

Maintaining a separate market for small groups (option 3) also eliminates the danger of adverse risk selection. It would also avoid the potential for "rate shock" for currently insured employees. The major disadvantages of this option are:

- It would not allow the small employers and their employees to get the benefits of an exchange, i.e., consumer choice and reduced employer administrative costs.
- It would not achieve "seamlessness". 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 considerations:

- An additional issue is the different rating pools and rating rules between the small group and individual market. If small groups were to be included, there would need to be additional changes such as modifying the rating rules (same rate bands in both markets) and combining the two risk pools.
- If there is no alternative to using the exchange, it will be necessary for the exchange to offer superior service in order to minimize the complaints that are likely to accompany this scenario.

For Category G (medium-sized and large employers), the option of requiring them to use the exchange is not possible due to the ERISA pre-emption of state regulations of health benefits for self-insured employers. The benefits of using the exchange are less than for small groups, since most larger groups

already offer consumer choice and can more easily absorb the costs of administering health benefit plans.

Allowing them the option to participate might raise the danger of adverse selection in the exchange, depending on the rating regulations inside the exchange.

Issue 2: Possible Functions and Roles of an Exchange

An insurance exchange can play a variety of roles. The options range from a relatively narrow role, with a limited set of functions, to a broader role, with a longer list of functions. An exchange could provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

1. Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans.
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment.
- Establish a process to confirm eligibility and administer 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, e.g., employees who work for employers not offering health benefits.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.
- Ensure provision of customer services, e.g., provide (or coordinate with brokers and carriers) to provide information, support, advocacy and referral for problems regarding benefit interpretation, claims payment, etc.
- 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.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

2. Benchmarking and Standards

- All of the functions above, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information)
- Establish agent and broker role in distribution and marketing of plans offered in the exchange
- 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

All carriers that meet the benchmark standards would contract with the exchange to offer coverage through the exchange.

Note: this category should be viewed as a continuum, depending on how the performance benchmarks are set. If the standards were set relatively low, there would be more carriers participating, and the exchange would be operating similar to tier 1. If the standards were set

relatively high, however, there would be fewer carriers, and this would begin to look more like tier 3, described below.

3. Rate Negotiation and Selective Contracting

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

Discussion

What are the pros and cons of having the exchange exercise a broader range of functions?

If the goals of **Lowering Costs and Improving Quality** are considered important, some would argue that a broader role for the exchange would help to achieve them. This depends, however, on what one believes about which approach is most effective.

- Some believe that a "consumer-driven" approach is sufficient; consumers who are price-sensitive and have access to transparent information on cost and quality (level 1) will choose the carriers (and their affiliated provider networks) that offer the best value.
- Others believe that consumers acting alone cannot move the market and that an "agent" (e.g., a large employer, public purchaser, or an exchange) is needed to establish benchmarks and comparable benefit packages (level 2). In this model, consumers make choices among carriers (and their affiliated provider networks) in a more structured market. (Note: this would be strengthened by a "defined contribution"-type formula for subsidized individuals, rather than the "percent of premium" arrangement under the current FHIAP program.)
- Finally, some believe that the competitive model (implicit in both of the above approaches) is not effective due to the special nature of the health care market. As a result, it would be necessary for the exchange to negotiate rates and selectively contract with carriers (level 3).

Note: the preceding discussion also applies to the goal of **Maximizing the Value of Government Contributions for Low-Income People**, with an additional factor. Those receiving government contributions would be somewhat less price-sensitive, so the likelihood of achieving consumer-driven value (in level 1) would be less. For this population, it would probably require the use of level 2 or 3 strategies.

Other implications of a broader role for the exchange:

- **Carrier Participation** would be encouraged due to streamlined marketing/enrollment and risk adjustment functions, but it might be discouraged if the administrative costs were too high, if purchasing standards (in level 2) were considered too stringent, or if rate negotiation (in level 3) led to rates that were considered too low. This would have a corresponding effect on **Consumer Choice.**
- Many of the information, enrollment and administration services are currently provided by **insurance brokers and agents**. If we develop 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 level 1, it would probably make sense for brokers and agents to continue their current role in the individual and small group markets. If, however, the exchange operates at level 2 (Benchmarking & Standards) or level 3 (Rate Negotiation and Selective Contracting) 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.

Health Insurance Exchange Options: Who Uses the Exchange?

Categories of participants that could benefit by using an exchange:

A. Individuals receiving state premium contributions (income between 150-300% FPL)
B. Individuals receiving tax credits for premium purchase (income between 300-400% FPL)
C. Individuals not eligible for employer's ESI, but who can use Sect. 125 plan (income above 400% FPL)
D. Individuals working for non-offering employer, who use Section 125 plan (income above 400% FPL)
E. Self-employed or non-employed individuals with income above 400% FPL
F. Employees of small employer groups
G. Employees of medium and large employer groups

Categories A, B and C are the core of an insurance exchange. Most of these people are currently uninsured; the exchange would offer services to help them purchase coverage. If the exchange operates at level 2 or 3, this would help to meet the goal of **maximizing the value of government contributions** (including premium contributions, tax credits and taxable income exclusions).

Category D individuals (employed persons working for a non-offering employer) tend to work for so-called "micro-employers" with only a few employees. One reason to require all such employees to enter the exchange is that this is a category of employees that tend to move between subsidized and unsubsidized coverage. Approximately 70% of individuals employed by non-offering employers are subsidy eligible. Of the remaining 30%, some will be eligible for a tax credit; the rest fit into Category D. Requiring that such individuals access coverage through 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 E (self-employed or non-employed with income above 400% FPL), could be treated in 3 ways:

1. **Include them** in the exchange (single individual market based on exchange)

   Pros: Avoids adverse selection spiral in the exchange
   Seamlessness – easier to move between subsidized and unsubsidized coverage without changing carrier
   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)

   Cons: 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 participation** in the exchange or purchase outside (dual market with a "permeable wall")

   Pros: Allows the exchange to prove its value as consumers "vote with their feet"
   Less disruptive - allows individuals to stay with their current carrier
   Access to exchange services
   Increases population to spread exchange's fixed administrative costs

   Cons: Danger of adverse risk selection unless regulatory, administrative steps are taken (such steps could restrict market offerings inside exchange)

3. **Do not allow participation** in the exchange (dual market with an "impermeable wall")

   Pros: Avoids adverse selection spiral in the exchange
   Less disruptive -- allows individuals to stay with their current carrier

For the Assumptions and Possible Goals for an Exchange, please see the full document.

Cons: Less seamlessness – people moving between subsidized and unsubsidized coverage may have to change carriers
Less efficient use of exchange infrastructure, fewer people access exchange's services

In many ways, Category E (small employers groups) could benefit the most from an exchange:

- It would **offer choice to consumers**, most of whom do not have a choice of carrier in their current small group coverage. This might have a secondary effect on **lowering costs and improving quality** in the delivery system and insurance administration.
- It would **reduce employers' administrative costs** by delegating the benefits administration and enrollment functions to the exchange.

For Category F there are three options:

1. **Include them** in the exchange (consolidate the individual and small group markets)

   Pros: Avoids adverse selection spiral in the exchange
   Seamlessness – easier to move between individual and small group coverage without changing carrier
   Simplifies enrollment process

   Cons: Potential for "rate shock" for older persons.
   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 participation** in an exchange or purchase outside (dual small group market with a "permeable wall")

   Pros: Possibly increased choice
   Cons: Significant danger of adverse risk selection in the exchange

3. **Do not allow participation** in the exchange (keep the small group market separate from the individual market)

   Pros: Avoids adverse selection spiral in the exchange
   Avoids possibility of "rate shock"

   Cons: Would not allow small employers and employees to access exchange's benefits (consumer choice and lower employer administrative costs)
   Less seamlessness – people moving between individual and group coverage may have to change carriers

The biggest concern regarding optional participation by small groups in the exchange (option 2) is **adverse risk selection**, i.e., the possibility that high-risk groups would join the exchange, while low-risk groups remain outside the exchange. This danger with small groups is even greater than with self-pay individuals, since small groups are rated on a group basis while individuals are rated on an age-basis. Mitigating this risk would be more difficult, since it would require small group and individual rating regulations to be consistent. In addition, the small group and individual market have different rating pools and rating rules. If small groups were to be included, there would need to be additional changes such as modifying the rating rules (same rate bands in both markets) and combining the two risk pools.

For Category G (medium and large employers), the option of requiring them to use the exchange is not possible due to the ERISA pre-emption of state regulations of health benefits for self-insured employers. The benefits of using the exchange are less than for small groups, as most larger groups already offer consumer choice and can more easily absorb the costs of administering health benefit plans. In addition, allowing them the option to participate could raise the danger of adverse selection in the exchange, depending on the rating regulations inside the exchange.

Possible Functions and Roles of an Exchange

An insurance exchange can play a variety of roles. The options range from a relatively narrow role, with a limited set of functions, to a broader role, with a longer list of functions. An exchange could provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

1. Information, Enrollment and Administration

- Create a central clearinghouse for information about health plan and insurance product choices, i.e., act as a mechanism to bring together consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and provide transparent information on cost, quality and service to support informed consumer choice of health plans.
- Manage open enrollment process by creating an efficient and user-friendly mechanism for health plan enrollment.
- Establish a process to confirm eligibility and administer 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, e.g., employees who work for employers not offering health benefits.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.
- Ensure provision of customer services, e.g., provide (or coordinate with brokers and carriers) to provide information, support, advocacy and referral for problems regarding benefit interpretation, claims payment, etc.
- Train agents and brokers on exchange functions; connect people with agents and brokers
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance

2. Benchmarking and Standards

- All of the functions above, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes (evidence-based standards, disease management programs, provider payment structures, publication of data, useful consumer information).
- 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.
- Establish agent and broker role in distribution and marketing of plans offered in the exchange.

All carriers that meet the benchmark standards would contract with the exchange to offer coverage through the exchange.

Note: this category should be viewed as a continuum, depending on how the performance benchmarks are set. If the standards were set relatively low, there would be more carriers participating, and the exchange would be operating similar to tier 1. If the standards were set relatively high, however, there would be fewer carriers, and this would begin to look more like tier 3, described below.

For the Assumptions and Possible Goals for an Exchange, please see the full document.

3. Rate Negotiation and Selective Contracting

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

Discussion

What are the pros and cons of having the exchange exercise a broader range of functions?

If the goals of **Lowering Costs and Improving Quality** are considered important, some would argue that a broader role for the exchange would help to achieve them. This depends, however, on what one believes about which approach is most effective.

- Some believe that a "consumer-driven" approach is sufficient; consumers who are price-sensitive and have access to transparent information on cost and quality (level 1) will choose the carriers (and their affiliated provider networks) that offer the best value.
- Others believe that consumers acting alone cannot move the market and that an "agent" (e.g., a large employer, public purchaser, or an exchange) is needed to establish benchmarks and comparable benefit packages (level 2). In this model, consumers make choices among carriers (and their affiliated provider networks) in a more structured market. (Note: this would be strengthened by a "defined contribution"-type formula for subsidized individuals, rather than the "percent of premium" arrangement under the current FHIAP program.)
- Finally, some believe that the competitive model (implicit in both of the above approaches) is not effective due to the special nature of the health care market. As a result, it would be necessary for the exchange to negotiate rates and selectively contract with carriers (level 3).

Note: the preceding discussion also applies to the goal of **Maximizing the Value of Government Contributions for Low-Income People**, with an additional factor. Those receiving government contributions would be somewhat less price-sensitive, so the likelihood of achieving consumer-driven value (in level 1) would be less. For this population, it would probably require the use of level 2 or 3 strategies.

Other implications of a broader role for the exchange:

- **Carrier Participation** would be encouraged due to streamlined marketing/enrollment and risk adjustment functions, but it might be discouraged if the administrative costs were too high, if purchasing standards (in level 2) were considered too stringent, or if rate negotiation (in level 3) led to rates that were considered too low. This would have a corresponding effect on **Consumer Choice.**

Many of the information, enrollment and administration services are currently provided by **insurance brokers and agents**. If we develop 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 level 1, it would probably make sense for brokers and agents to continue their current role in the individual and small group markets. If, however, the exchange operates at level 2 (Benchmarking & Standards) or level 3 (Rate Negotiation and Selective Contracting) 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.

EXCHANGE ADMINISTRATION

Should the Exchange be a public entity, a contracted private entity, or a public service nonprofit?

	Public Agency	**Public-Private Hybrid**	**Private Organization**
Flexibility in hiring, contracting, vendor choice	Low	High	High
Start up time and costs	Lower – can utilize existing state resources for hiring, payroll, accounts payable, etc	Medium – can rely on some state resources but will need to create own payroll, accounts payable, other systems can contract with state agencies for specific tasks	High – must create own payroll, accounts payable and other systems
Speed of purchasing	Slower – time-consuming procurement process	Quicker– limited constraints	Quicker – limited constraints
Accountability and transparency	Very – built into state rules	Dependent on rules established, more difficult to ensure	Dependent on rules established, more difficult to ensure
Independence	Low – responsibility to report to Legislature, Governor and Agency chiefs built in	Medium – governing rules may require reporting	High – may not be bound by legislative or administrative reporting requirements

Examples

- Oregon Lottery
  - The five-member Oregon Lottery Commission is appointed by the Governor and confirmed by the Senate. Commission members serve at the pleasure of the Governor and are appointed for terms of four years.
  - Revenues that are not used for prizes are used to fund education, economic development, and natural resources defense programs.

- SAIF
  - SAIF Corporation is Oregon's not-for-profit, state-chartered workers' compensation insurance company.
  - SAIF was created by the people of Oregon through the Oregon state legislature. Began in 1914 as a state agency, and in 1980 became the nation's first public corporation specializing in workers' compensation insurance.
  - Issues more than 50% of all policies in the state, covering 35% of the workforce.

  - SAIF's competitiveness helps keeps Oregon's pure premium rates among the lowest in the nation; rates have declined or remained steady in every year since 1990.
  - Administration
    - 5-member Board of Directors appointed by the Governor
    - Executive Director of 9-member Executive Council is appointed by the Board
    - 843 employees

- Massachusetts Commonwealth Connector Authority
  - The Connector operates as an independent public authority under the Department of Administration and Finance and is overseen by a separate, appointed Board of private and public representatives.
    - Under the health reform law, the legislature established the Connector Board to ensure access to high-quality, affordable health insurance. The ten member board comprises three appointees of the Attorney General, three gubernatorial appointments and four ex officio members. The Executive Director is appointed by the Administration and Finance Secretary.
  - It is a quasi-public agency, has latitude in hiring and picking vendors
    - Other aspects can cost more – They had to hire a director of accounting, and buy financial reporting systems needed to run the business.
  - The Connector staff is small – about 40-45 people (mostly managers and their support staff)
  - Each director level person has one to three people working for them, doing research, policy work, regulatory work (not running operations).

Market Reforms – Straw Plan and Issue Development

In previous discussions, the Exchange Workgroup agreed that market reforms should include:

- An individual mandate;
- Guaranteed issue and guaranteed renewability;
- No pre-existing condition provision;
- Public subsidies for lower income Oregonians;
- Establishment of an essential services benefit package that is affordable, accessible, and consumer-valued; and
- Continued DCBS 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.

In addition, in a reformed market carriers should compete based on the efficiency of their administration, on delivery system and network adequacy, and on other quality and service differences, rather than on a given plan's ability to get better risk. Based on these assumptions, the workgroup identified a number of issues that must be addressed for reforms to be successful. What follows is a "straw plan" for discussion and development by the workgroup.

1. **Risk Pool**
    a. One individual market pool.
    b. No pre-enrollment medical screening to determine rates or insurability or to create a separate high-risk pool. (Post-enrollment, insurer may be allowed to conduct health risk appraisal for management purposes.)

2. **Risk Management Options**
    a. Utilize risk adjustment mechanism to shift revenue between carriers based on the risk enrolled in each plan. Carriers that enroll high risk individuals receive more revenue; those with lower risk individuals receive less.
    b. Assess options for risk adjustment (prospective, retrospective), recognizing that it may be affected by existence of a voluntary Exchange.
    c. Recognizing that the state of the art in risk adjustment continues to evolve, a mechanism will be established to ensure the methodology established for risk adjustment is routinely reviewed and modified to ensure its ongoing value and efficacy. Application of the risk adjuster will be done by qualified and independent personnel and outside experts as needed.

3. **Financing Mechanism for High Risk Enrollees**
    a. The costs of the high risk and portability pools need to considered in the total risk pool but how those costs should be spread needs further study and a transition plan may need to be considered. Part of the challenge is capturing the annual $80 million currently collected to support OMIP.
    b. The current OMIP population may be initially held apart from the individual market, and transitioned into the general individual market over time. This may be a

financing separation or an actual separation of pools. Holding the OMIP enrollees apart would require additional premium assistance for current OMIP enrollees, so that their premiums are the same as those in the individual market (to limit OMIP enrollees' incentive to leave OMIP for the regular market).

c. Consider impact of introducing the current portability pool into the main individual market pool, as people in portability coverage are on average higher risk than the individual market.

4. Benefit Design

a. The Benefits Committee will define an essential services benefit that meets the individual mandate.

b. Carriers will file plans with DCBS to show that they meet or exceed the essential services benefit.

c. All products with benefits equal to or greater than essential services benefit must be offered on guaranteed issue basis.

d. Supplemental plans or disease-specific plans may or may not be subject to guaranteed issue. (Need more information on supplemental plans not considered health insurance under state code.)

e. Carriers will offer a plan equal to the essential services benefit defined by the Benefits Committee, and may offer plans that are "buy ups" from the basic benefit. To limit adverse selection to insurers based on plan offerings, pricing for higher benefit plans will be set to make these plans actuarially equivalent to the benchmark plan.

f. Once an essential services benefit is established, consider establishing (3-5) standardized benefit tiers. The first tier includes the essential services benefit defined in d, with additional tiers that are actuarially defined so that a benefit plan in level one is actuarially 60% of a plan in level three. Determining the appropriate number of tiers will depend on the richness of the essential services benefit.

g. The young adults (20-25) should not be considered differently, unless the cost of the basic benefit plan required and the initial enrollment of this population is low.

h. The Exchange could consider becoming more prescriptive with benefit plans if risk adjustment alone does not do enough to control risk selection.

5. Plan Enrollment Period

a. Individuals sign up and may change carriers or benefit plans only during annual open enrollment period (as is done in Medicare Advantage). Want to limit individual's attempts to game system by rapid switching between plans and in/out of insurance.

b. Assumes there is an effective way to get all or most Oregonians enrolled.

c. An individual enrolling from a period of non-coverage (choosing to not enroll when eligible) can only enroll during the next open enrollment period, and only into the essential services benefit plan until the next open enrollment.

d. An appeals and enrollment-period exceptions process will be developed 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. Similar to group market change of life event provisions.

e. Will develop rules regarding mandate responsibility for minors and others considered dependents.

f. Insurers are regulated to ensure their compliance with annual open enrollment period.

g. Work Group will work with Eligibility and Enrollment Committee regarding residency requirements for state premium participation.

6. Transition Period Efforts

a. Need work during transition period (moving from existing market to new), assuring fair and equitable movement with costs absorbed in a way that does not hurt the success of an individual pool.

7. Group Market and Groups of One

a. In absence of regulatory changes that align benefits and mandates in individual and group markets, do not change how groups of one are treated. As currently, groups of one will be eligible for the individual market and not group. Currently the individual market does not include the coverage mandates now required in the group market. If groups of one are allowed, sicker self-employed people will enter group market for the richer coverage, while healthier self-employed people will go into the individual market to get better rates.

b. In this discussion, "group of one" is a self-employed individual with no employees, not a employee group in which only one employee takes up employer-offered insurance.

c. Further discussion maybe required regarding differences between group and individual markets once the benefits are established.

8. Rating

a. The medical component of rates in the individual market will be based on each carrier's experience for all individual market enrollees, whether inside or outside the exchange.

b. Use statute or regulation to increase transparency in administrative and medical cost components of rates.

c. Start with a natural rate band based on actual experience of the overall individual market (between 5 or 6, estimated at 5.7 currently). Reevaluate after several years, retaining the possibility of lowering the rate band over time.

d. Continue to use age to determined rates. Do not use gender or health status.

e. Standardize use of age bands. All carriers (within and outside the exchange) will use consistent (5 year) age bands for rating for enrollees over age 19.

f. There will be one rate band for enrollees age 19 and under. This band must comply with the natural rate band spread

g. Keep small group market as it is regarding rating (rather than change it to match the individual market). Evaluate for impact over time; allow policy change if small groups are enrolled in exchange and/or disruption is found.

h. Due to the cost and difficulty of administering such rate adjustments, do not require carriers to utilize premium discounts for "healthy behaviors" (not smoking, enrollment in wellness programs). Allow the market to encourage healthy behaviors through means other than rating.

i. Monitor for selection issues, include in DCBS review.

j. Allow geography-based rating. Evaluate the impact of this course over time and make adjustments to policy if necessary.

9. Limiting Disruption for Current Individual Market Enrollees

a. The penalty for non-coverage must be high enough to encourage current enrollees to retain their coverage.

b. Many current enrollees will see some increase in rates.

c. Assess how to reduce impact on low income enrollees; do we allow these individuals into the subsidy program?

d. Utilize a phased in approach in order to transition currently insured into market with minimal disruption. Consider retaining current OMIP enrollees in program for some period in order to mediate the impact on individual market rates. Assumes additional subsidy of OMIP premiums so that enrollees do not pay higher than individual market rate.

e. Determine whether persons currently enrolled in employer sponsored plans who would be financially eligible for premium assistance will be allowed to access state premium contributions.

10. Maintaining Carrier Participation

a. Individual requirement enforcement rules must be strong.

b. Implement strong risk adjustment.

Note on Individual Mandate: Through discussion with the chair and vice-chair of the Eligibility and Enrollment committee, the Exchange Work Group has determined that operationalizing an individual mandate is part of the work of the Work Group. The issues involved in establishing an individual mandate are set out in a separate document, for review by a staff review panel and discussion by the Exchange Work Group.

Insurance Exchange Options

Key Issues

Two critical and complex issues in the design of an insurance exchange:

1. What are its roles and functions?
2. Who may (or must) purchase through the exchange?

Issue 1: Possible Functions and Roles of an Exchange

An insurance exchange can play a variety of roles. We can select from this "menu" to produce a range of options. The options range from a relatively narrow role, with a limited set of functions, to a broader role, with a longer list of functions. An exchange could be configured to provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

1. Information, Enrollment and Administration

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

- Ensure provision of post-enrollment customer services, e.g., provide or coordinate with brokers and carriers to provide information, support, advocacy and referral for problems regarding benefit interpretation, claims payment, etc.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

2. Benchmarking and Standards

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

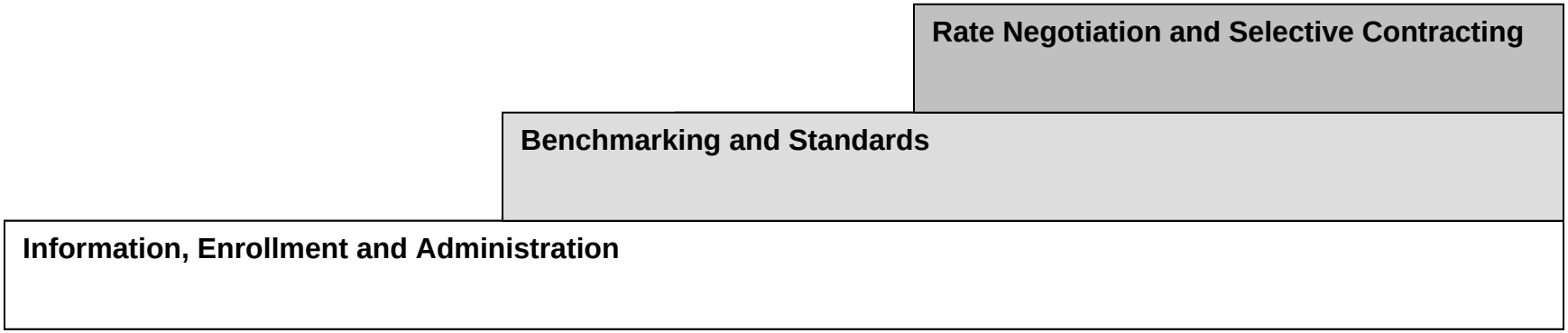
All carriers that meet the benchmark standards could participate in the exchange.

Note: this category should be viewed as a continuum, depending on how the performance benchmarks are set. If the standards were set relatively low, there would be more carriers participating, and the exchange would be operating similar to tier 1. If the standards were set relatively high, however, there would be fewer carriers, and this would begin to look more like tier 3, described below.

3. Rate Negotiation and Selective Contracting

- All of the functions above, plus:
- Solicit bids or price proposals.

- Negotiate prices and/or discounts with carriers.
- Select which carriers would participate in the exchange.



To evaluate this range of options, it is useful to articulate the goals of an exchange. The following is an initial list of possible goals:

- **Help Consumers Shop for Insurance**: by providing consumers with clear and comparable information regarding carriers, provider networks and benefit plan options available to them.
- **Make it Easy for Consumers to Enroll**: by providing an efficient and user-friendly mechanism for enrollment in health plans.
- **Help Consumers and Insurers with Payment Processing**: by providing a mechanism to collect and aggregate premium contributions from multiple sources, including administration of subsidies.
- **Help Consumers by Offering Customer Service**: by providing information, support, advocacy and referral for problems regarding benefit interpretation, claims payment decisions, etc.
- **Encourage Carriers to Participate in the Exchange:** by streamlining the marketing and enrollment functions, and by protecting carriers from adverse risk selection via risk adjustment or reinsurance mechanisms.

- **Make it Easy for Consumers to Compare Options:** by standardizing or categorizing benefit plans offered by carriers.
- **Offer Choice to Consumers:** by ensuring that consumers have a choice of multiple carriers, providers and delivery systems.
- **Lower Costs and Improve Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System:** for example, by establishing standards for carrier participation, evaluating carriers and their provider networks, encouraging healthy competition based on quality and efficiency
- **Lower Costs and Improve Quality for Consumers by Encouraging Innovation and Improvements in Insurance Administration:** through innovations in provider payment, incentives for efficient administration and effective customer service.
- **Maximize benefit of state-funded subsidies:** by ensuring that taxpayer dollars are deployed to obtain the best value.

[See additional possible goals below in discussion of Issue 2.]

Issue 2: Who must or may purchase through the exchange?

The design of an insurance exchange is affected by the number and characteristics of the participants. There are three categories of participants that would potentially benefit the most by using an exchange:

A. Individuals – subsidized

B. Individuals – non-subsidized
C. Employees who use Sec.125 contributions from a non-offering employer or are not eligible for coverage
D. Small employer groups and their employees. (Note: this could be phased in, e.g., begin with groups with 2-10 employees, expand to all groups up to 25 employees, and then later expand to all groups up to 50 employees.)

For each of these categories, participation in the exchange could be required or voluntary. Requiring the use of the exchange seems most compelling for the first category. The pros and cons of voluntary or required participation for the other groups are discussed below.

Note: it is possible to consider adding other populations to the exchange beyond these options. For example, it would be possible to open the exchange to medium and large employers and their employees on a voluntary basis. Required use of the exchange for these groups would not be possible, however, due to the ERISA exemption for self-insured employer groups.)
Note 2: there are also some sub-categories that may warrant different policies. For example, there are people who work for employers offering coverage, but they are not eligible for coverage – for example, part-time workers. Should they be required to use the exchange, as those who work for a non-offering employer are? This will require further analysis and discussion.

In evaluating who should be included, three other goals should be considered:

- **Minimize the disruption** for current (mostly non-subsidized) consumers in the individual market.
- **Encourage participation of carriers** in the individual market generally, regardless of the presence and role of an exchange.
- Make it easy for consumers to move between subsidized and non-subsidized individual coverage, as well as between individual and small group coverage, i.e., **"seamlessness"**.
- Facilitate the task of **managing risk selection** to avoid an adverse risk spiral in any market segment.

Summary of Options

Assumption: There will be reforms to the individual market, e.g., guaranteed Issue and elimination of current high risk pool, with a new mechanism to address the costs for high risk individuals. All of this assumes there will be an individual mandate. I would reverse columns B and C or just have the 125 discussion as a separate item

		Categories of Enrollees Potentially Entering Exchange			
		A. Individuals – subsidized (required)	B. Employees who use Sec.125 contributions from a non-offering employer or are not eligible for coverage	C. Individuals – non-subsidized (voluntary or required)	D. Small employer groups and their employees (voluntary or required)
Exchange Functions	Tier 1: Information, Enrollment & Administration	**1A**	**1B (vol)** **1B (req)**	**1C (vol)** **1C (req)**	**1D (vol)** **1D (req)**
	Tier 2: Benchmarking and Standards	**2A**	**2B (vol)** **2B (req)**	**2C (vol)** **2C (req)**	**2D (vol)** **2D(req)**
	Tier 3: Rate Negotiation & Selective Contracting	**3A**	**3B (vol)** **3B (req)**	**3C (vol)** **3C (req)**	**3D (vol)** **3D (req)**

Discussion

The goals of **Consumer Shopping, Enrollment, Payment Processing,** and **Customer Service** would be met in all options. Expanding the size of the exchange (i.e., including categories B and C) would offer these benefits to more people.

> *Implications and related issues* – many of these services are currently provided by insurance brokers and agents. If we develop an exchange, it will be important to consider an appropriate role, appointment process and payment structure for brokers and agents. For example, within the exchange it may be appropriate for brokers to be appointed and paid by the exchange rather than by carriers. This could limit the number of participating brokers/agents, and the payment structure might be based on something other than a percentage of premium.

There is a range of issues that emerge when looking at the potential advantages and disadvantages of including groups other than subsidy users in the exchange. (This can be viewed as moving across the columns of the matrix to include non-subsidized individuals and small groups.)

1. What are the benefits or disadvantages of **increasing the *size*** of the exchange? Potential advantages include:
    - A larger pool would spread any 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 [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
    - A larger pool would spread the risk more broadly, provide more stability for the pool over time, and potentially lessen the danger of an adverse risk spiral. As with spreading fixed administrative costs, the benefit of this is significant up to a certain level [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
    - *If* the goals of **Lowering Costs and Improving Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System and Insurance Administration** are considered important, a larger exchange could have more influence in the market – especially if the exchange worked closely with other large public and private purchasers. This would also depend on the role that the exchange chooses, especially if it set high performance benchmarks for carrier participation in the exchange (i.e., the "upper" end of Tier 2 functions). If the exchange were relatively small – i.e., subsidized

individuals (category 1) only, which would be approximately 100,000 people – some carriers might choose to not participate rather than try to meet the standards. If the exchange were larger, however, those carriers might try to meet the performance benchmarks rather than abandon this market segment. At its largest (i.e., including the entire combined individual and small group markets), the exchange would include approximately 700,000 people [*caution: very rough estimate],* which would be just under 20% of the total market (3.7 million). As noted above, its influence on Lowering Costs and Improving Quality could be enhanced if it worked with other public and private employers/purchasers to use consistent measures, performance standards and purchasing practices.

On the downside, including more categories of people in the exchange could create implementation challenges. Even if the eventual goal is to create a large exchange, it may be prudent to phase in the various categories gradually to maximize the likelihood of successful implementation.

2. What are the advantages and disadvantages of **voluntary vs. mandatory** participation for non-subsidized individuals and small groups? On one hand, a voluntary arrangement has intrinsic appeal. It allows the exchange to prove its value as consumers "vote with their feet", choosing to join or not to join the exchange. It also means the current individual market remains intact and requires benefits and pricing structures in and outside of the exchange to be the same to minimize selection. However, the biggest concern regarding voluntary participation is **risk selection**, i.e., the possibility that high-risk individuals or groups would join the exchange, while low-risk individuals or groups remain outside the exchange. This would lead to an adverse selection spiral within the exchange; historically, this has occurred frequently with exchanges in other states.

   The problem of risk selection can be mitigated – at least to some degree – by the following:

   - Application of the same insurance regulations (e.g., guaranteed issue, rating, benefit design, etc.) inside and outside the exchange. [Note: the rating methodology would need to be the same, but the rates themselves would not have to be identical, e.g., there might be different administrative loading factors inside and outside of the exchange.]
   - Use of a risk adjustment mechanism between the two segments (in the exchange vs. outside of the exchange) [*Is this feasible? How would it work?]*

- Establishment of eligibility and participation rules for small groups in the exchange.

The question remains: would these steps be sufficient to minimize the risk of adverse selection in a voluntary arrangement?

Regarding non-subsidized individuals (Category C above), it appears – on balance – that voluntary participation would not be preferable. Allowing individuals to choose whether or not to use the exchange does have the advantages discussed above, but there are a few significant disadvantages. These include:

- If participation is voluntary, the potential for risk selection is likely to be significant. This potential could be mitigated to some degree, but not entirely, by requiring the same rates and benefit designs inside and outside the exchange and by using a risk adjustment mechanism.
- If an individual market exists outside the exchange, insurers' administrative and marketing expenses would remain the same or potentially increase if they were to participate in both.
- If participation is voluntary, there may be no advantage for carriers to participate in both, especially if the exchange assumes Tier 2 functions (Benchmarking & Standards), insurers may choose not to participate in the exchange. This would be especially likely if the benchmarks for participation are high.
  - Participating in the exchange would require extra effort on the part of carriers to meet the standards. This would seem unnecessary as long as their plans can still be offered outside the exchange. In this situation, insurers who choose to participate in the exchange might feel vulnerable to non-exchange insurers pursuing risk selection strategies.

Requiring individuals to use the exchange would eliminate the danger of risk selection between the two markets (inside and outside the exchange). It would also simplify the entrance process for consumers and reduce carriers' marketing costs. The disadvantages of requiring individuals to use the exchange include:

- If the exchange assumes Tier 2 functions, some insurers might not be able to meet the standards or would choose to exit the market. To the extent this occurred, current enrollees would have to switch to a different insurer.

- While marketing costs may decline, the cost of administering the exchange would likely offset that reduction to some degree.
- Self- and non-employed individuals would not benefit as greatly from the administrative efficiencies provided by the exchange as others would, such as small employer groups. The burdens of enrolling more than one person, billing employees, making plan payments, etc. do not exist for self- and non-employed individuals, but those efficiencies would be great for small employer groups.
- If there is no alternative to using the exchange, it will be necessary for the exchange to offer superior service in order to minimize the complaints that are likely to accompany this scenario.

3. There are several other implications of including more people in the exchange. As more categories are included, it would make it easier for people who shift from subsidized to unsubsidized or individual to group coverage, i.e., the goal of **seamlessness** would be met. On the other hand, including more categories might be **more disruptive** for people who currently have individual or small group coverage, especially if the carrier and benefit options within the exchange were different from their current coverage.

What are the pros and cons of having the exchange exercise a **broader range of functions**? (This can be viewed as moving down the rows of the matrix to include Benchmarking & Standards and Rate Negotiation/Selective Contracting.)

If the goals of **Lowering Costs and Improving Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System and Insurance Administration** are considered important, some would argue that a broader role for the exchange would help to achieve them. This depends, however, on what one believes about which approach is most effective.

- Some believe that a "consumer-driven" approach is sufficient; consumers who are price-sensitive and have access to transparent information on cost and quality will choose the carriers (and their affiliated provider networks) that offer the best value.

- Others believe that consumers acting alone cannot move the market and that an "agent" (e.g., a large employer, public purchaser, or an exchange) is needed to establish benchmarks and comparable benefit packages. In this model, consumers make choices among carriers (and their affiliated provider networks) in a more structured market. (Note: this would be strengthened by a "defined contribution"-type formula for subsidized individuals, rather than the "percent of premium" arrangement under the current FHIAP program.)
- Finally, some believe that the competitive model (implicit in both of the above approaches) is not effective due to the special nature of the health care market. As a result, it would be necessary for the exchange to negotiate rates and selectively contract with carriers.

Note: the preceding discussion also applies to the goal of **Maximizing the Value of State-funded Subsidies**.

Other implications of a broader role for the exchange:

- **Carrier Participation** would be encouraged due to streamlined marketing/enrollment and risk adjustment functions, but it might be discouraged if the purchasing standards (in level 2) were considered too stringent or if rate negotiation (in level 3) led to rates that were considered too low. This would have a corresponding effect on **Consumer Choice.**

OHFB Market Reform & Exchange Design Work Group

Issues regarding an Individual Health Insurance Requirement

Background

The Oregon Health Fund Board's list of Design Assumptions includes:

> *All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available.*

This is driven by the Design Principle that:

> *The responsibility and accountability for the financing and delivery of health care is shared by all Oregonians."*

Rationale

Some individuals – those who can afford coverage as well as those who cannot -- choose to forego insurance. When they become seriously sick or injured, however, they rely on hospitals which are required to provide emergency services to everyone regardless of coverage. The health care costs for these uninsured people are borne by those who have insurance, via the cost shift. Requiring all Oregonians to have health insurance is needed to minimize the cost shift.

In addition, a personal coverage requirement is needed if other market reforms are undertaken. In particular, this requirement is needed to avoid adverse selection if we were to adopt guaranteed issue in the individual market (i.e., the elimination of medical screening for eligibility). Without this requirement, the guaranteed issuance of individual coverage is not feasible.

Issues

The following issues have emerged in the Work Group's discussion of market reform and exchange design. (Note: this is a *preliminary* list, and we expect to add to and modify it after further discussions.)

1. A benchmark benefit design must be defined for the purpose of determining that the individual health insurance requirement has been met. (The Work Group assumes that the Benefits Committee will develop this benchmark benefit design.)
    a. How comprehensive or limited should this benefit be? If it is more comprehensive than the benefit plans currently held by individual consumers, it would require them to "buy-up". This could be very disruptive to a large number of individuals who have been paying for coverage. If it is more limited, however, it might expose individuals to unaffordable out-of-pocket costs.
    b. How would the benchmark benefit design needed to meet the individual health insurance requirement be applied to employer-based coverage? If the benchmark benefit is more comprehensive than the benefit plans offered by some or most

employers, it would require individuals to purchase supplemental coverage or push their employers to offer more comprehensive coverage. This could be disruptive in the large segment of people who already have coverage, and monitoring and enforcement might be difficult. Some have suggested considering any employer-based coverage to meet the individual health insurance requirement.

2. To maximize the number of people who comply with the individual health insurance requirement, both participation incentives and non-participation penalties will be needed.
    a. The financial penalty for non-coverage should be significant, e.g., at least 50% (?) of the cost of the benchmark plan; it does not need to equal the cost of coverage, since the non-participating person will not be getting the benefits of coverage.
    b. Should the penalty be based on % of premium? If it is age-rated, the penalty would be relatively costly for older individuals. If it is flat dollar amount based on the average premium (or age 40-44), it would be a stiffer penalty for younger individuals (i.e., a higher percentage of their premiums).
    c. The penalty for non-coverage must be high enough to encourage current enrollees to retain their coverage.
    d. Due to administrative issues, there should not be a surcharge on insurance for delayed purchase (as in Medicare Part B)?
    e. We may want to consider other incentives, e.g., require evidence of coverage in order to get a driver's license or for school enrollment.
3. To minimize the problems of adverse risk selection in the insurance market, we should consider a rule that an individual enrolling from a period of non-coverage can only enroll during the next open enrollment period, and only into the benchmark plan.
    a. Should we also consider implementing a penalty for individuals entering coverage from a period of non-coverage?
4. We will need to develop rules regarding responsibility for minors and other dependents.
    a. How should penalties be applied if some members of a household are not covered while others have coverage?
5. Effective enforcement of the individual health insurance requirement is key.
    a. Which entities (Revenue, Employment, carriers, others?) should monitor compliance with the individual health insurance requirement? For non-subsidized people, it may make sense to use the tax system to monitor compliance. For example, insurers and TPAs (or employers) would report the names of covered persons to the state, which would compare the names to a master list compiled from Revenue, Employment, DMV, etc.) An alternative would be voluntary reporting on individual state income tax returns (with a requirement to file even if no tax is owed).
    b. Which entity administers penalties for non-participation? How and when are penalties applied? The Revenue Dept has an established process and can administer the penalty as they do other penalties. Rules would need to be established to direct the agency on how to apply. This may require statutes or administrative rules to support administration by the department.

6. Other issues:
    a. How to determine compliance?
    b. How often to determine compliance?
    c. What period counts for having insurance (at start or end of year, for 12 months)? Is continuous coverage required throughout the year? How should penalties be applied if a person has coverage for only part of the year? Should we consider pro-rated penalties? It may make sense for monitoring and enforcement rules to be consistent with the way that subsidy eligibility rules are applied (e.g., 3-month, 6-month, or 12-month eligibility).
    d. Exceptions
    e. Appeal process

Possible Principles for Design and Enforcement of an Individual Health Insurance Requirement

1. KIS – make it easy to administer, easy to comply, easy to verify coverage.
2. Fairness – people who can afford coverage should buy it, while lower-income people may need assistance to make coverage affordable.
3. Flat of the curve – we should recognize that getting 100% compliance is probably impossible and very expensive; 99% may be sufficient to meet the goals of reducing the cost shift and minimizing adverse selection.
4. Others?

Oregon
Theodore R. Kulongoski, Governor

Office for
Oregon Health Fund Board
General Services Building
1225 Ferry St. SE
1st Floor
Salem, OR 97301
(503) 373-1779
FAX (503) 378-5511

February 4, 2008

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

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

Dear President Courtney and Speaker Merkley:

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

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

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

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

Sincerely,

Barney Speight
Director

HEALTH INSURANCE EXCHANGES AND MARKET REFORM

Introduction

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

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

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

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

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

Overview

An Important Element of Comprehensive Reform

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

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

Benefits of an Exchange

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

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

Previous Attempts to Run Exchanges

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

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

The Massachusetts Connector

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

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

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

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

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

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

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

The Oregon Market

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

Oregon's Insurance Markets Differ from Those in Massachusetts

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

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

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

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

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

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

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

Insurance Regulations

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

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

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

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

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

Role of an Exchange in Broader Reform

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

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

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

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

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

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

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

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

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

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

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

Options for Exchange Functions

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

Tier 1: Information, Enrollment and Administration

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

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

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

Tier 2: Benchmarking and Standards

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

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

Tier 3: Rate Negotiation and Selective Contracting

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

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

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

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

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

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

List of Appendices

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

Oregon Health Fund Board

Bill Thorndike, Chair
President, Medford Fabrication

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

Eileen Brady
Co-Owner, New Seasons Market

Tom Chamberlain
President, Oregon AFL-CIO

Charles Hofmann, MD
Physician

Ray Miao
President, Oregon Chapter, AARP

Marcus Mundy
President, Urban League of Portland

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

Finance Committee

Kerry Barnett, Chair
Executive Vice President
The Regence Group

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

Andy Anderson
CFO & Senior Vice President
Cascade Corporation

Peter Bernardo, MD
Private Practice, General Surgery

Fred Bremner, DMD
Private Practice

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO, Lane Individual Practice Association, Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Jim Diegel
President and CEO
Cascade Healthcare

Steven Doty
President and Owner
Northwest Employee Benefits, Inc.

Laura Etherton
Advocate
Oregon State Public Interest Research Group

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

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

David Hooff
Vice President, Finance
Northwest Health Foundation

John Lee
Consultant, Strategic Affairs
Providence Health Systems

Judy Muschamp
Tribal Health Director
Confederated Tribes of Siletz

Steve Sharp
Chairman of the Board
TriQuint Semiconductor, Inc.

Scott Sadler
Owner, The Arbor Cafe

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

Exchange Work Group

Denise Honzel, Chair
Healthcare Consultant

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

Kerry Barnett
Executive Vice President
The Regence Group

Damian Brayko
Director, Small Group and Individual
Kaiser Permanente Northwest

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO
Lane Individual Practice Assn., Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Steve Doty
President and Owner
Northwest Employee Benefits, Inc.

Chris Ellertson
President
Health Net Health Plan of Oregon

Jack Friedman
CEO
Providence Health Plans

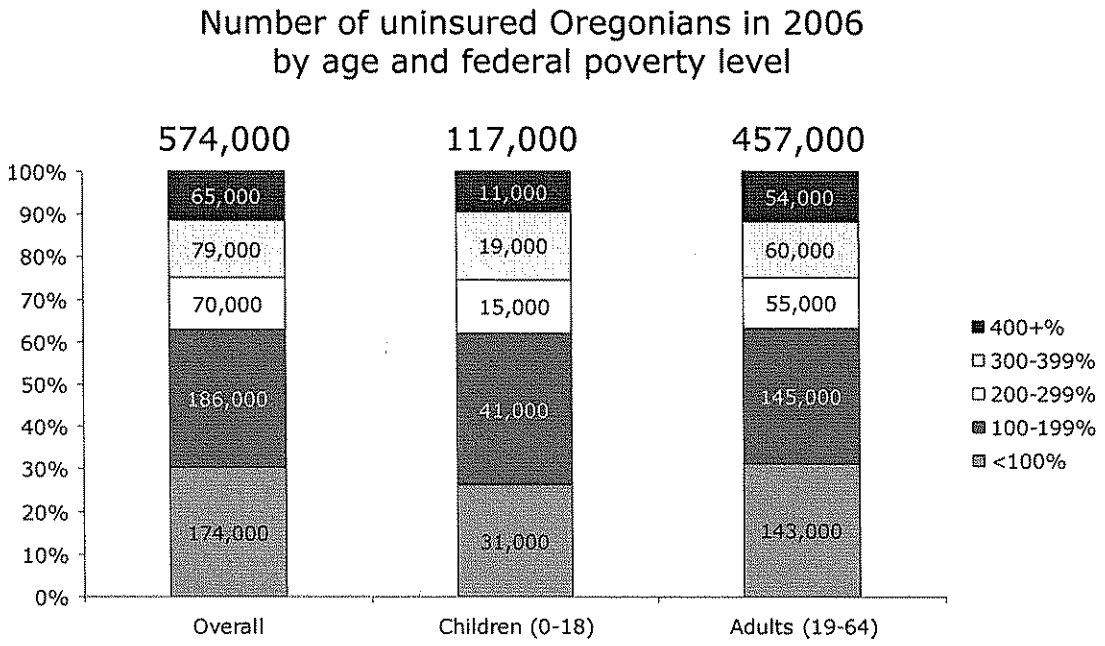
Jon Jurevic
Senior Vice President, Chief Financial Officer
ODS Companies

Ken Provencher
President and CEO
Pacific Source Health Plans

Nina Stratton
Owner
The Stratton Company

Kelsey Wood
Gordon Wood Insurance

Appendix 2



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

Appendix 3

Individual and Small Group Market Shares, Oregon (2005)

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

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

Market Reforms – Straw Plan and Issue Development

In previous discussions, the Exchange Workgroup agreed that market reforms should include:

- an individual mandate;
- guaranteed issue and guaranteed renewability,
- no pre-existing condition provision;
- public subsidies for lower income Oregonians;
- affordable, accessible, consumer-valued insurance is available; and
- Continue DCBS review of insurance rates to ensure that rates, reserves and margins are not excessive.

In addition, in a reformed market carriers should compete based on the efficiency of their administration, on delivery system and network adequacy, and on other quality and service differences, rather than on a given plan's ability to get better risk. Based on these assumptions, the workgroup identified a number of issues that must be addressed for reforms to be successful. What follows is a "straw plan" for discussion and development by the workgroup.

1. **Risk Pool**
   a. One individual market pool.
   b. No pre-enrollment medical screening to determine rates or insurability or to create a separate high-risk pool. (Post-enrollment, insurer may be allowed to conduct health risk appraisal for management purposes.)

2. **Risk Management Options**
   a. Prospective risk adjustment mechanism to shift revenue between carriers based on the risk enrolled in each plan. Carriers that enroll high risk individuals receive more revenue; those with lower risk individuals receive less.
   b. Recognizing that the state of the art in risk adjustment continues to evolve, a mechanism will be established to ensure the methodology established for risk adjustment is routinely reviewed and modified to ensure its ongoing value and efficacy. Application of the risk adjuster will be done by qualified and independent personnel and outside experts as needed.

3. **Financing Mechanism for High Risk Enrollees**
   a. Will discuss with Rick Curtis (consultant on Market Reform) how to spread costs associated with high risk enrollees once OMIP (and its associated assessment) goes away. Part of the challenge is capturing the annual $80 million currently collected to support OMIP (and whatever additional cost associated by additional high cost enrollees entering the system).

4. Benefit Design

a. The Benefits Committee will define a benchmark benefit that meets the individual mandate.

b. All products with benefits equal to or greater than benchmark must be offered on guaranteed issue basis.

c. Supplemental plans or disease-specific plans may or may not be subject to guaranteed issue. (Need more information on supplemental plans not considered health insurance under state code.)

d. Carriers will offer a plan equal to the benchmark benefit defined by the Benefits Committee, and may offer plans that are "buy ups" from the basic benefit. To limit adverse selection to insurers based on plan offerings, pricing for higher benefit plans will be set to make these plans actuarially equivalent to the benchmark plan.

e. Consider establishing 3 standardized benefit levels. The first level is the benchmark benefit defined in d, with additional benefit levels that are actuarially defined so that a level one benefit plan is actuarially 60% of a level three benefit plan.

f. Carriers must offer same benefit plans inside and outside of the exchange.

g. Every carrier must offer one or more plans (equivalent to the baseline benefit), and may offer others.

h. The Exchange could consider becoming more prescriptive with benefit plans if risk adjustment alone does not do enough to control risk selection.

5. Plan Enrollment Period

a. Individuals sign up and may change carriers or benefit plans only during annual open enrollment period (as is done in Medicare Advantage). Want to limit individual's attempts to game system by rapid switching between plans and in/out of insurance.

b. Assumes individuals will be subject to a financial penalty for non-coverage.

c. An individual enrolling from a period of non-coverage (choosing to not enroll when eligible) can only enroll during the next open enrollment period, and only into the benchmark plan until the next open enrollment.

d. An appeals and exemption process will be developed 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. Similar to group market change of life event provisions.

e. Will develop rules regarding mandate responsibility for minors and others considered dependents.

f. Insurers are regulated to ensure their compliance with annual open enrollment period.

g. Need to identify and mediate impact such a requirement could have on rates.

6. Transition Period Efforts

a. Need work during transition period (moving from existing market to new), assuring fair and equitable movement with costs absorbed in a way that does not hurt the success of an individual pool.

7. Group Market and Groups of One

a. In absence of regulatory changes that align benefits and mandates in individual and group markets, do not change how groups of one are treated. As currently, groups of one will be eligible for the individual market and not group. Currently the individual market does not include the coverage mandates now required in the group market. If groups of one are allowed, sicker self-employed people will enter group market for the richer coverage, while healthier self-employed people will go into the individual market to get better rates.

b. Further discussion maybe required regarding differences between group and individual markets once the benefits are established.

8. Rating

a. The medical component of rates in the individual market will be based on each carrier's experience for all individual market enrollees, whether inside or outside the exchange.

b. Continue to use a natural rate band based on actual experience of the overall individual market (between 5 or 6, estimated at 5.7 currently)

c. Continue to use age to determined rates. Do not use gender or health status.

d. Standardize use of age bands. All carriers (within and outside the exchange) will use consistent (5 year) age bands for rating for enrollees at or above age 19.

e. Consider 10 year age bands for 30-50 year olds.

f. Special rules may be adopted for enrollees under 18 years (using different number of years in rate bands for children).

g. There will be one rate band for enrollees under 18 years. This band must comply with the natural rate band spread

h. Depending on the cost of the basic benefit plan required, a lower option for 19-25 may be considered.

i. Keep small group market as it is regarding rating rather than change it to match the individual market. Evaluate this for impact over time;, allow changes to be made if disruption is found.

j. Due to the cost and difficulty of administering such rate adjustments, do not require carriers to utilize premium discounts for "healthy behaviors" (not smoking, enrollment in wellness programs). Allow the exchange to work with carriers to encourage healthy behaviors through means other than rating.

k. Allow geography-based rating. Evaluate the impact of this course over time and make adjustments to policy if necessary.

9. Limiting Disruption for Current Individual Market Enrollees

a. The penalty for non-coverage must be high enough to encourage current enrollees to retain their coverage.

b. Many current enrollees will see some increase in rates.

c. Assess how to reduce impact on low income enrollees; do we allow these individuals into the subsidy program?

d. Utilize a phased in approach in order to transition currently insured into market with minimal disruption. Consider retaining current OMIP enrollees in program for some period in order to mediate the impact on individual market rates. Assumes additional subsidy of OMIP premiums so that enrollees do not pay higher than individual market rate.

10. Maintaining Carrier Participation

a. Individual requirement enforcement rules must be strong. (NOTE: this is all I have, not sure how to expand)

b. Implement strong risk adjustment.

11. Benefit Plan for Young Adults

a. Initially do not offer a young adult plan (lower price point paired with skinnier benefits/increased cost sharing/lower annual or lifetime limits.

b. In the future, consider the desirability and feasibility of offering a young adult plan to encourage this segment to purchase coverage.

Note on Individual Mandate: Through discussion with the chair and vice-chair of the Eligibility and Enrollment committee, the Exchange Work Group has determined that operationalizing an individual mandate is part of the work of the Work Group. The issues involved in establishing an individual mandate are set out in a separate document, for review by a staff review panel and discussion by the Exchange Work Group.

Insurance Exchange Options

Key Issues

Two critical and complex issues in the design of an insurance exchange:

1. What are its roles and functions?
2. Who may (or must) purchase through the exchange?

Issue 1: Possible Functions and Roles of an Exchange

An insurance exchange can play a variety of roles. We can select from this "menu" to produce a range of options. The options range from a relatively narrow role, with a limited set of functions, to a broader role, with a longer list of functions. An exchange could be configured to provide services from tier 1 only, tiers 1 and 2, or from all three tiers.

1. Information, Enrollment and Administration

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

- Provide a mechanism to collect and aggregate premium contributions from multiple sources, e.g., for employees who work part-time for multiple employers that do not offer full health benefits.
- Provide post-enrollment customer services, e.g., provide information, support, advocacy and referral for problems regarding benefit interpretation, claims payment, etc.
- Administer mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.

2. Benchmarking and Standards

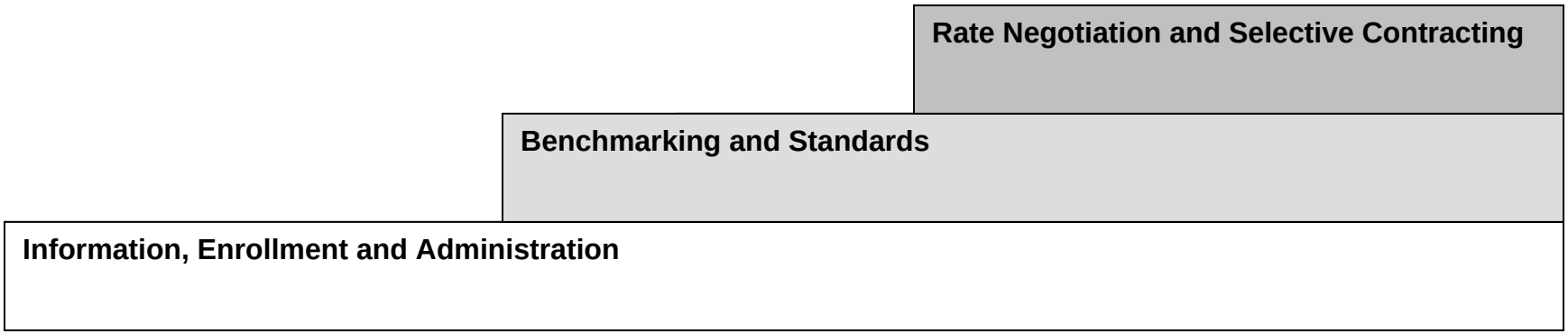
- All of the functions above, plus:
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection.
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes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

All carriers that meet the benchmark standards could participate in the exchange.

Note: this category should be viewed as a continuum, depending on how the performance benchmarks are set. If the standards were set relatively low, there would be more carriers participating, and the exchange would be operating similar to tier 1. If the standards were set relatively high, however, there would be fewer carriers, and this would begin to look more like tier 3, described below.

3. Rate Negotiation and Selective Contracting

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



To evaluate this range of options, it is useful to articulate the goals of an exchange. The following is an initial list of possible goals:

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

[See additional possible goals below in discussion of Issue 2.]

Issue 2: Who must or may purchase through the exchange?

The design of an insurance exchange is affected by the number and characteristics of the participants. There are three categories of participants that would potentially benefit the most by using an exchange:

A. Individuals – subsidized and those who use Sec.125 contributions from a non-offering employer
B. Individuals – non-subsidized
C. Small employer groups and their employees. (Note: this could be phased in, e.g., begin with groups with 2-10 employees, expand to all groups up to 25 employees, and then later expand to all groups up to 50 employees.)

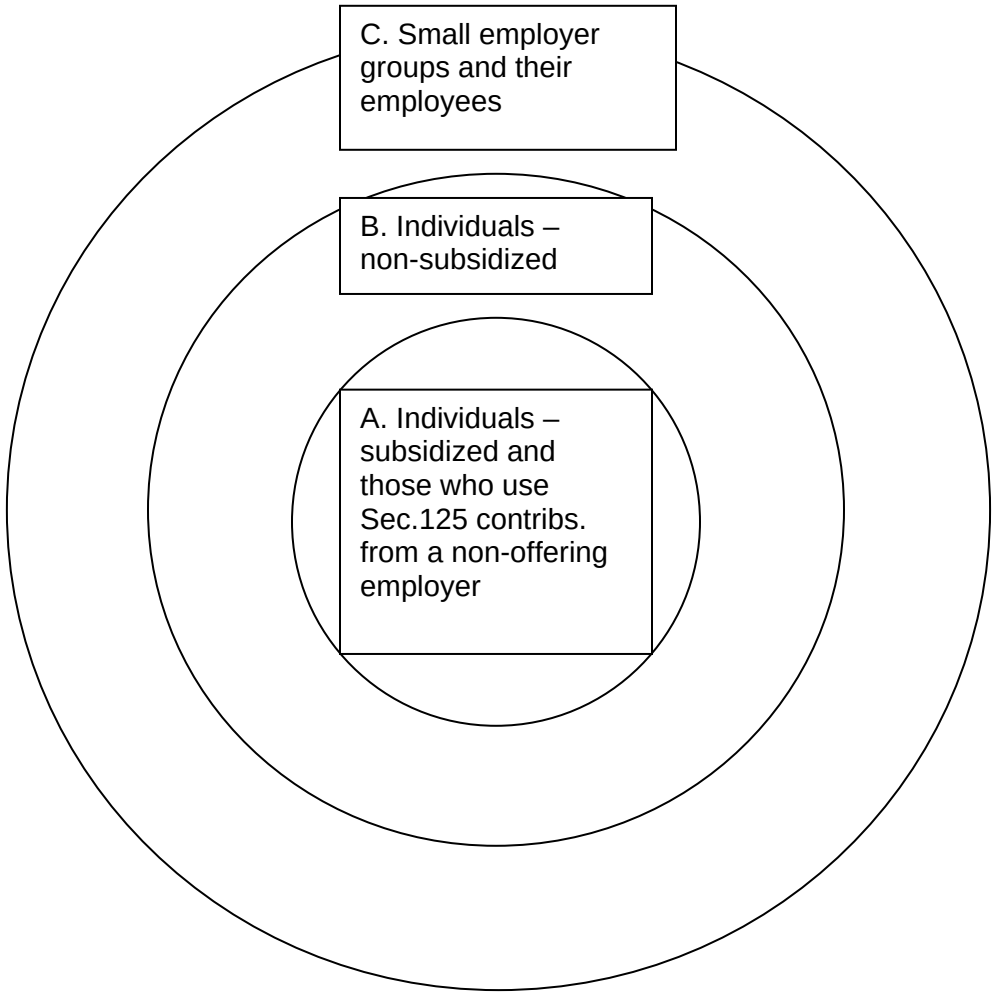
For each of these categories, participation in the exchange could be required or voluntary. Requiring the use of the exchange seems most compelling for the first category. The pros and cons of voluntary or required participation for the other groups are discussed below.

Note: it is possible to consider adding other populations to the exchange beyond these options. For example, it would be possible to open the exchange to medium and large employers and their employees on a voluntary basis. Required use of the exchange for these groups would not be possible, however, due to the ERISA exemption for self-insured employer groups.)

Note: there are also some sub-categories that may warrant different policies. For example, there are people who work for employers offering coverage, but they are not eligible for coverage – for example, part-time workers. Should they be required to use the exchange, as those who work for a non-offering employer are? This will require further analysis and discussion.

In evaluating who should be included, three other goals should be considered:

- **Minimize the disruption** for current (mostly non-subsidized) consumers in the individual market.
- **Encourage participation of carriers** in the individual market generally, regardless of the presence and role of an exchange.
- Make it easy for consumers to move between subsidized and non-subsidized individual coverage, as well as between individual and small group coverage, i.e., **"seamlessness"**.
- Facilitate the task of **managing risk selection** to avoid an adverse risk spiral in any market segment.


C. Small employer groups and their employees
B. Individuals – non-subsidized
A. Individuals – subsidized and those who use Sec.125 contribs. from a non-offering employer

Summary of Options

Assumption: There will be reforms to the individual market, e.g., guaranteed Issue and elimination of current high risk pool, with a new mechanism to address the costs for high risk individuals. All of this assumes there will be an individual mandate.

		Categories of Enrollees Potentially Entering Exchange			
		A. Individuals – subsidized and those who use Sec.125 contributions from a non-offering employer(required)	B. Individuals – non-subsidized (voluntary or required)		C. Small employer groups and their employees (voluntary or required)
Exchange Functions	Tier 1: Information, Enrollment & Administration	**1A**	**1B (vol)** **1B (req)**		**1C (vol)** **1C (req)**
	Tier 2: Benchmarking and Standards	**2A**	**2B (vol)** **2B (req)**		**2C (vol)** **2C(req)**
	Tier 3: Rate Negotiation & Selective Contracting	**3A**	**3B (vol)** **3B (req)**		**3C (vol)** **3C (req)**

Discussion

The goals of **Consumer Shopping, Enrollment, Payment Processing,** and **Customer Service** would be met in all options. Expanding the size of the exchange (i.e., including categories B and C) would offer these benefits to more people.

> *Implications and related issues* – many of these services are currently provided by insurance brokers and agents. If we develop an exchange, it will be important to consider an appropriate role, appointment process and payment structure for brokers and agents. For example, within the exchange it may be appropriate for brokers to be appointed and paid by the exchange rather than by carriers. This could limit the number of participating brokers/agents, and the payment structure might be based on something other than a percentage of premium.

There is a range of issues that emerge when looking at the potential advantages and disadvantages of including groups other than subsidy users in the exchange. (This can be viewed as moving across the columns of the matrix to include non-subsidized individuals and small groups.)

1. What are the benefits or disadvantages of **increasing the *size*** of the exchange? Potential advantages include:
    - A larger pool would spread any 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 [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
    - A larger pool would spread the risk more broadly, provide more stability for the pool over time, and potentially lessen the danger of an adverse risk spiral. As with spreading fixed administrative costs, the benefit of this is significant up to a certain level [up to 100,000?], but the incremental benefit is small as the pool grows even larger.
    - *If* the goals of **Lowering Costs and Improving Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System and Insurance Administration** are considered important, a larger exchange could have more influence in the market – especially if the exchange worked closely with other large public and private purchasers. This would also depend on the role that the exchange chooses, especially if it set high performance benchmarks for carrier participation in the

exchange (i.e., the "upper" end of Tier 2 functions). If the exchange were relatively small – i.e., subsidized individuals (category 1) only, which would be approximately 100,000 people – some carriers might choose to not participate rather than try to meet the standards. If the exchange were larger, however, those carriers might try to meet the performance benchmarks rather than abandon this market segment. At its largest (i.e., including the entire combined individual and small group markets), the exchange would include approximately 700,000 people [*caution: very rough estimate],* which would be just under 20% of the total market (3.7 million). As noted above, its influence on Lowering Costs and Improving Quality could be enhanced if it worked with other public and private employers/purchasers to use consistent measures, performance standards and purchasing practices.

On the downside, including more categories of people in the exchange could create implementation challenges. Even if the eventual goal is to create a large exchange, it may be prudent to phase in the various categories gradually to maximize the likelihood of successful implementation.

2. What are the advantages and disadvantages of **voluntary vs. mandatory** participation for non-subsidized individuals and small groups? On one hand, a voluntary arrangement has intrinsic appeal, and based on the argument that it would allow the exchange to prove its value as consumers "vote with their feet" to join or not join the exchange. The biggest concern regarding voluntary participation is **risk selection**, i.e., the possibility that high-risk individuals or groups would join the exchange, while low-risk individuals or groups remain outside the exchange. This would lead to an adverse selection spiral within the exchange; historically, this has occurred frequently with exchanges in other states.

   The problem of risk selection can be mitigated – at least to some degree – by the following:

   - Application of the same insurance regulations (e.g., guaranteed issue, rating, benefit design, etc.) inside and outside the exchange. [Note: the rating methodology would need to be the same, but the rates themselves would not have to be identical, e.g., there might be different administrative loading factors inside and outside of the exchange.]
   - Use of a risk adjustment mechanism between the two segments (in the exchange vs. outside of the exchange) [*Is this feasible? How would it work?]*

- Establishment of eligibility and participation rules for small groups in the exchange.

The question remains: would these steps be sufficient to minimize the risk of adverse selection in a voluntary arrangement?

3. There are several other implications of including more people in the exchange. As more categories are included, it would make it easier for people who shift from subsidized to unsubsidized or individual to group coverage, i.e., the goal of **seamlessness** would be met. On the other hand, including more categories might be **more disruptive** for people who currently have individual or small group coverage, especially if the carrier and benefit options within the exchange were different from their current coverage.

What are the pros and cons of having the exchange exercise a **broader range of functions**? (This can be viewed as moving down the rows of the matrix to include Benchmarking & Standards and Rate Negotiation/Selective Contracting.)

If the goals of **Lowering Costs and Improving Quality for Consumers by Encouraging Innovation and Improvements in the Quality and Efficiency of the Delivery System and Insurance Administration** are considered important, some would argue that a broader role for the exchange would help to achieve them. This depends, however, on what one believes about which approach is most effective.

- Some believe that a "consumer-driven" approach is sufficient; consumers who are price-sensitive and have access to transparent information on cost and quality will choose the carriers (and their affiliated provider networks) that offer the best value.
- Others believe that consumers acting alone cannot move the market and that an "agent" (e.g., a large employer, public purchaser, or an exchange) is needed to establish benchmarks and comparable benefit packages. In this model, consumers make choices among carriers (and their affiliated provider networks) in a more structured market. (Note: this would be strengthened by a "defined contribution"-type formula for subsidized individuals, rather than the "percent of premium" arrangement under the current FHIAP program.)

- Finally, some believe that the competitive model (implicit in both of the above approaches) is not effective due to the special nature of the health care market. As a result, it would be necessary for the exchange to negotiate rates and selectively contract with carriers.

Note: the preceding discussion also applies to the goal of **Maximizing the Value of State-funded Subsidies**.

Other implications of a broader role for the exchange:

- **Carrier Participation** would be encouraged due to streamlined marketing/enrollment and risk adjustment functions, but it might be discouraged if the purchasing standards (in level 2) were considered too stringent or if rate negotiation (in level 3) led to rates that were considered too low. This would have a corresponding effect on **Consumer Choice.**

OHFB Market Reform & Exchange Design Work Group

Issues regarding a Health Insurance Coverage Requirement

Background

The Oregon Health Fund Board's list of Design Assumptions includes:

> *All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available.*

This is driven by the Design Principle that:

> *The responsibility and accountability for the financing and delivery of health care is shared by all Oregonians.*

Rationale

Some individuals – those who can afford coverage as well as those who cannot -- choose to forego insurance. When they become seriously sick or injured, however, they rely on hospitals which are required to provide emergency services to everyone regardless of coverage. The health care costs for these uninsured people are borne by those who have insurance, via the cost shift. A requirement that all Oregonians have health insurance is needed to minimize the cost shift.

In addition, a health insurance coverage requirement is needed if other market reforms are undertaken. In particular, this requirement is needed to avoid adverse selection if we were to adopt guaranteed issue in the individual market (i.e., the elimination of medical screening for eligibility). Without this requirement, the guaranteed issuance of individual coverage is not feasible.

Issues

The following issues have emerged in the Work Group's discussion of market reform and exchange design. (Note: this is a *preliminary* list, and we expect to add to and modify it after further discussions.)

1. A benchmark benefit design must be defined for the purpose of determining that the health insurance coverage requirement has been met. (The Work Group assumes that the Benefits Committee will develop this benchmark benefit design.)
    a. How comprehensive or limited should this benefit be? If it is more comprehensive than the benefit plans currently held by individual consumers, it would require them to "buy-up". This could be very disruptive to a large number of individuals who have been paying for coverage. If it is more limited, however, it might expose individuals to unaffordable out-of-pocket costs.

   b. How would the benchmark benefit design needed to meet the health insurance coverage requirement be applied to individuals with employer-based coverage? If the benchmark benefit is more comprehensive than the benefit plans offered by some or most employers, it would require individuals to purchase supplemental coverage or push their employers to offer more comprehensive coverage. This could be disruptive in the large segment of people who already have coverage, and monitoring and enforcement might be difficult. Some suggest considering any employer-based coverage acceptable coverage with respect to the health insurance coverage requirement.

2. To maximize the number of people who comply with the health insurance coverage requirement, both participation incentives and non-participation penalties will be needed.

   a. The financial penalty for non-coverage should be significant, e.g., at least 50% (?) of the cost of the benchmark plan; it does not need to equal the cost of coverage, since the non-participating person will not be getting the benefits of coverage.

   b. Should the penalty be based on % of premium? If it is age-rated, the penalty would be relatively costly for older individuals. If it is flat dollar amount based on the average premium (or age 40-44), it would be a stiffer penalty for younger individuals (i.e., a higher percentage of their premiums).

   c. The penalty for non-coverage must be high enough to encourage current enrollees to retain their coverage.

   d. Due to administrative issues, there should not be a surcharge on insurance for delayed purchase (as in Medicare Part B)?

   e. We may want to consider other incentives, e.g., require evidence of coverage in order to get a driver's license or for school enrollment.

3. To minimize the problems of adverse risk selection in the insurance market, we should consider a rule that an individual enrolling from a period of non-coverage can only enroll during the next open enrollment period, and only into the benchmark plan.

   a. Should we also consider implementing a penalty for individuals entering coverage from a period of non-coverage?

4. We will need to develop rules regarding responsibility for minors and other dependents.

   a. How should penalties be applied if some members of a household are not covered while others have coverage?

5. Effective enforcement of the health insurance coverage requirement is key.

   a. Which entity or entities (Revenue, Employment, carriers, others?) should monitor compliance with the health insurance coverage requirement? For

non-subsidized people, it may make sense to use the tax system to monitor compliance. For example, insurers and TPAs (or employers) would report the names of covered persons to the state, which would compare the names to a master list compiled from Revenue, Employment, DMV, etc.) An alternative would be voluntary reporting on individual state income tax returns (with a requirement to file even if no tax is owed).

b. Which entity administers penalties for non-participation? How and when are penalties applied? The Revenue Dept has an established process and can administer the penalty as they do other penalties. Rules would need to be established to direct the agency on how to apply. This may require statutes or administrative rules to support administration by the department.

6. Other issues:
    a. How to determine compliance?
    b. How often to determine compliance?
    c. What period counts for having insurance (at start or end of year, for 12 months)? Is continuous coverage required throughout the year? How should penalties be applied if a person has coverage for only part of the year? Should we consider pro-rated penalties? It may make sense for monitoring and enforcement rules to be consistent with the way that subsidy eligibility rules are applied (e.g., 3-month, 6-month, or 12-month eligibility).
    d. Exceptions
    e. Appeal process

Possible Principles for Design and Enforcement of a Health insurance Coverage Requirement

1. KIS – make it easy to administer, easy to comply, easy to verify coverage.
2. Fairness – people who can afford coverage should buy it, while lower-income people may need assistance to make coverage affordable.
3. Flat of the curve – we should recognize that getting 100% compliance is probably impossible and very expensive; 99% may be sufficient to meet the goals of reducing the cost shift and minimizing adverse selection.
4. Others?

Oregon Health Fund Board -- Finance Committee
Market Design/Insurance Exchange Work Group
Insurance Exchange Design Issues

The Task: An evaluation of and recommendations on the role an "insurance exchange" would play in a redesigned individual market, including individual choice of carrier and plan, and efficient administration of subsidies to eligible Oregonians. Address issues including but not limited to:

The Structure of an Exchange

- Organization of Exchange
- Governance structure
- Funding
- Ensuring sufficient enrollment/participation
- Role of brokers

Interaction between Subsidy and Exchange

- Who is offered subsidy
- Mandate use of Exchange for subsidy users?
- Products offered to those with and without subsidies
- Subsidy funding
- Coordination with the Family Health Insurance Assistance Program

Individual Participation

- Mandatory and voluntary participants
- Minimum enrollment period requirement? Enforcement mechanism
- Portability across employers and from Medicaid to employer coverage
- Use of pre-tax dollars to purchase premiums
- Support choice via decision support tools & cost, quality, service information

Employer Participation

- Open or limited employer participation
- Employer incentives for participation
- Encouraging/maintaining employer sponsored coverage
- Premium aggregation for employees with multiple employers
- Minimum financial participation by employer for participation?

Health Plan Participation

- Inclusion of all affordable health plan options
- Allow all willing plan or limit to select group of plans
- provider compensation, transparency, medical home, EHR incentives
- Minimum coverage requirements?
- Development of packages that manage care, quality and cost
- Appropriate use of 125 plans

The Work Group will make recommendations to the Finance Committee by March 15, 2008. The Finance Committee will deliberate and forward final recommendations to the Board by April 30, 2008.

What problems are we trying to solve by creating an Insurance Exchange?

- Individuals are not able to use the purchasing advantages of large groups, such as:
  - Lower administrative costs
  - Ability to negotiate rates with insurers
  - Ability to encourage improvements in the delivery system
- Individuals are not able to benefit from other programs which are offered by many employers, e.g.,
  - Participation or incentives for health promotion and wellness
  - Assistance from HR staff in selecting health plans
- Employed individuals who are not covered by their employer cannot use the tax advantages of employer-based coverage.
- It is difficult for individual consumers to obtain clear and comparable information on all of the health plan options, including the high risk pool, available to them, even with the help of insurance brokers and agents as well as newer web-based tools.
- There is no way to collect and aggregate premium contributions if a person is employed by multiple employers but not eligible for employer-sponsored coverage

What opportunity is created by the proposed comprehensive reform plan?

The proposed comprehensive reform plan includes a requirement for individuals to have health insurance; this will change the dynamics of the individual market. Specifically, it would bring a large group of new individuals into the market – an estimated 150-200,000 people who currently do not have coverage. In addition, there may be other reform elements, e.g., guaranteed issue and subsidies, which would affect this market. This would require a mechanism to determine eligibility and administer subsidies efficiently on a large scale. It is therefore appropriate to consider mechanisms that would enhance the ability for these consumers to shop more effectively and efficiently for health coverage.

Possible Objectives for an Insurance Exchange

- Provide an easy process for consumers to shop for coverage, e.g., clear and comparable information on the health plan options available to them.
- Provide an efficient process for enrolling in health plans
- Reduce administrative costs for purchasing coverage
- Provide a mechanism to determine eligibility and administer subsidies efficiently and on a large scale
- Allow individuals to benefit from the purchasing advantages of large groups.
- Allow individuals to benefit from other value-based purchasing initiatives, e.g., health promotion and wellness, which are offered by many large employers.
- Provide a mechanism to collect and aggregate premium contributions if a person is employed by multiple employers but not eligible for employer-sponsored coverage, or to use contributions from employers who offer cash instead of employer-sponsored health benefits.
- If possible, enable employed individuals who are not covered by their employer to use the tax advantages of employer-based coverage.
- Could support employers in setting up Sec. 125 plans through use of agents/brokers
- Promote competition to design products that meet individuals' price and coverage needs
- Minimize the disruption for individuals (e.g., being forced to switch health plans and/or providers) when moving between small group, individual and Medicaid markets.

♦ Possible Functions of an Exchange

An insurance exchange could fulfill a variety of functions. We can select from this "menu" to produce a range of options:

- Create a central clearinghouse for information about choices of health plans and insurance products, i.e., a mechanism to bring together a group of consumers to facilitate the purchase of health coverage from a variety of health plans
- Design decision support tools and 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 enrollment in health plans.
- Provide a mechanism to collect and aggregate premium contributions from multiple sources
- Establish standardized or comparable tiered benefits offered by health plans – to clarify and simplify the consumer choice process, minimize unnecessary variation, facilitate comparison shopping and minimize risk selection [see note below]
- Design mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.
- Establish market regulations to avoid an adverse risk spiral within the exchange
- Establish a process to confirm eligibility and administer subsidies for low-income individuals [see note below]
- Use value-based purchasing strategies and support for wellness programs to drive improvements in quality, service and costs
- Promote competition by selecting the plans or products that can be offered rather than allowing all certified health plans to participate in the exchange.
- Negotiate prices and/or discounts with health plans and push for improved value
- Set or negotiate rates for participating health plans, or set benchmark price points, or solicit bids.

Assumptions:

- Eligibility for subsidies (as well as eligibility for OHP) will be determined by a single source (DHS?). The Exchange would only be responsible for ensuring that subsidies are applied only for eligible individuals.
- The Insurance Division will continue to review and certify that health benefit plans offered in Oregon meet regulatory requirements. The Exchange would only be responsible for ensuring that the benefit plans offered within the Exchange has been certified by the Insurance Division.

Other Issues

- *Who would be in the exchange?* Options include the following:
  1. All individuals getting insurance through the individual market would purchase coverage through the exchange, i.e. it would be the sole mechanism for all individuals to access the health insurance market
  2. All individuals who receive subsidies would purchase coverage through the exchange; the use of the exchange would be voluntary for non-subsidized individuals

Options	Pros	Cons
1. All individuals in the exchange	Maximizes size of pool; may increase purchasing power Minimizes the task of managing risk selection between separate pools Provides "seamlessness" for individuals moving between subsidized and unsubsidized coverage (to avoid changing health plan and/or provider)	May affect role of brokers and agents Problematic for insurers if exchange has ability to select insurers to be offered [see discussion of this issue below]
2. Subsidized individuals in the exchange; voluntary for non-subsidized	Provides additional option for non-subsidized individuals Allows insurers to participate in individual market, even if exchange has ability to select which insurers are offered	Smaller pool within the exchange Requires regulatory changes to minimize risk selection between separate pools, i.e., to ensure that rating and benefits are consistent inside and outside the exchange May create disruption for individuals (i.e., forcing them to switch insurers or providers) when moving between subsidized and unsubsidized coverage

- *Should the exchange have the ability to <u>select</u> which insurers can be offered, or should <u>all certified insurers</u> be allowed to participate in the exchange?*

Options	Pros	Cons
1. Exchange can select which insurers are offered	Would strengthen value based purchasing initiatives Might promote some degree of competition and result in lower rates and/or higher service and quality levels	Could effectively bar some insurers from the individual market, especially if all individuals (subsidized and non-subsidized) are purchasing through the exchange (see discussion of this issue, above)
2. All certified insurers may participate	No insurers excluded	Weaker value based purchasing initiatives May result in less effective competition based on price, service and quality

- *How can we achieve the goal of "portability" or "seamlessness", i.e., to allow people to move between individual coverage (subsidized and non-subsidized), employer-sponsored coverage and Medicaid with minimal disruption to their coverage, insurance plans, benefits, rates and provider relationships?* This will require a high degree of coordination in designing the small group market and Medicaid along with the individual market. If it is not possible to achieve "pure" seamlessness, what are the priorities: avoid gaps in coverage? Keep same provider? Maintain same level of benefits? Keep same insurer?

- *What organization should administer the exchange/purchasing pool?* Is it a public entity, a public service non-profit organization or a contracted private organization, or something else? [to be developed further].

- *How would the exchange be funded?* Options include:
  - a service fee for participants (individuals and employees of small businesses).
  - a fee for small businesses whose employees participate.
  - a surcharge on insurance premiums.
  - an opportunity fee from insurers who wish to bid for inclusion on the menu of offerings within the exchange.
  - a loan from the state and/or private foundations that would be repaid over time, or that could be a five year initial capitalization.

Market Reform and Health Insurance Exchange Workgroup
Timeline for Report Development and Review

December 6	Workgroup meets to discuss market problems, reform goals, and options
December	Staff drafts initial (descriptive) report on market reform changes, health insurance exchange issues
January 7 or 8	Workgroup edits report
January 9	Finance Committee reviews report
January (week 4)	Exchange gives final approval of report, conducts other business
February 1	"Draft" report goes to Legislature, with notation that Board has yet to give approval, report is subject to change by Board
February 13	Finance Committee approves report
February 19	Board gives approves report
February 20	Final report is given to the 2008 Legislature
February (TBD)	Workgroup continues its discussions of market reforms and health insurance exchange, in order to provide information to Finance Committee

Market Reform & Health Insurance Exchange
Initial "Issue Identification" List
12/02/07

A. Regulatory Changes to Insurance Market

1. OHFB assumption: individual mandate
   i. How is a mandate administered
   ii. Exemptions (who, why, whether and how to address affordability gap in exemptions)
2. Will Oregon utilize guaranteed issue, maintain OMIP, or use a new process
3. What market changes will affect health plans
4. Impact of pooling, underwriting, rating on the existing market
5. Is there a benefits "floor" (Benefits Committee)
   i. What is the floor
   ii. What happens if the floor is higher than what people are purchasing currently (how to manage impact on various groups affected)
6. Is there one pool or multiple pools
7. Are changes to existing regulations in various markets needed (additional regulations, amendments to regulations)

B. Role of an Exchange

1. Is the Exchange for the individual market only, does it include the small group market (immediately or at a later date)
2. To what, if any, extent does the Exchange perform a regulatory role (is the Exchange an information provider, a strong regulator, or somewhere in between)
3. Does the Exchange set prices
4. Does the Exchange set quality standards
5. Does it monitor and/or enforce any regulations

C. Structure and Duties of an Exchange

1. Type of entity (public/private/quasi-public, new agency/existing agency/state-sponsored private entity)
2. Governance
   i. Administered by OHFB or some other entity
   ii. If separate from OHFB, governing body (executive branch department, publicly appointed board of directors, CEO)
3. Funding
   i. OHFB design assumption: Financing should be broad-based, equitable, and sustainable
   ii. Health Policy Commission recommends sustainable, internally generated funding, could be supported by transaction fees, premiums, carrier membership fees, Medicaid administrative funds

4. Ensuring Viability – how to gain sufficient participation to be sustainable and influence quality and efficiency in the market (in what market – all, the individual market only, other configuration)
5. Is there an alternative to using the Exchange, and for what groups/individuals (also see individual participation)

D. Individual Participation

1. Who will be allowed to use the Exchange (all individuals, subsidy-users, employees of small businesses, all Oregonians)
2. Which participants may enroll voluntarily
3. Will any participants be mandated to enroll, and if so which ones
4. Will enrollment periods be enforced, and if so for what period
5. Can an individual move from a Medicaid or subsidized plan into unsubsidized coverage and retain the same insurance without disruption (will plans be offered across payment type)
6. Effect on families with access to insurance for some but not all members

E. Risk Adjustment, Risk Sharing

1. Will the Exchange engage in risk adjustment for plans enrolling members through the Exchange
2. If so, how will this be accomplished (retrospective smoothing of costs among carriers/excess-loss claims subsidies to cariers/other)
3. Is there a role for reinsurers, and if so what is that role
4. Should a model such as utilized by Washington's PEBB risk adjustment be considered
5. Should exchange reallocate money to plans with high risk/cost enrollees

F. Rate Methodology and Benefit Offerings

1. What products will be offered (how many, what types)
2. How is pricing determined
    i. Is one price set for all or do different products/companies have different prices
    ii. Are prices the same as outside the Exchange
    iii. Additional methodologies
3. Can people "buy up" from the basic package
4. Should a model such as used by Medicare be considered, in which eligibility and base benefit are defined, revenue is risk adjusted, buy-up is allowed, plans compete for business)

G. Product Offerings

1. How to ensure meaningful variation in plan design

H. Health Plan Participation

1. Will all health insurers be allowed to participate, or will participation be limited
2. If participation is limited, how will plans be chosen
   i. Licensed health insurers
   ii. IPAs, etc
   iii. Medicaid plans
   iv. Independent offerings/alternative care networks
   v. Only verticals, or allow others
3. Will there be requirements on participating plans (incentives for provider compensation, transparency, medical home, HER, etc)
4. If there are participation requirements, will the Exchange set the participation criteria, or will these rules be set by another entity (legislatively, regulatorily by an existing department)
5. Developing plans that manage care, quality, cost

I. Tax Treatment

1. Will individuals purchasing insurance be allowed to use pre-tax dollars to pay premiums
2. Will other tax relief be provided to individuals purchasing insurance on their own
3. For employers not offering employee health coverage, what is the advisability of requiring pre-tax use for the individual's use of their own money
4. Will Exchange be involved with employers' use of a 125 mechanism for payroll deduction
5. Will some employers be required to offer a 125 mechanism

J. Brokers

1. Role of brokers in reformed market that includes an Exchange
   i. Should we emulate Medicare or some other existing model
2. Can the Exchange's role and brokers' role be positive for both

K. Subsidy (Under discussion by Eligibility & Enrollment Committee)

1. Who will be eligible for subsidy
2. Will subsidy be based solely on income
3. Will subsidies be available for any insurance purchase or only for insurance purchased through the Exchange
4. Are the same insurance products offered to subsidized and unsubsidized users of the Exchange
5. How will subsidies be funded (provider tax, payroll tax, other tax, general fund revenues)
   i. If Federal funds are used, what restrictions apply
6. What is the interplay between the Exchange and the Family Health Insurance Assistance Program (FHIAP)
7. Will the Exchange provide transitional assistance to employers that want to start offering employee health insurance

8. Are subsidies available to individual for purchase of non-group insurance, purchase via employer-based insurance, or both

L. Affordability Standard (Under discussion by Eligibility & Enrollment Committee)

1. Definition of Affordability

M. Employer Participation

1. Can employers participate in the Exchange (none, small employers, all)
2. Incentives for employers to participate in the Exchange (tax relief, administrative support)
3. Will employers be required to pay a minimum percentage of employee premiums to participate in the Exchange
4. Will the Exchange provide administrative functions for employer accessing health plans through the Exchange (such as customer service, enrollment, premium collection, billing, reconciliation, etc.)
5. Will the Exchange utilize a Third Party Administrator for some or all of these activities
6. What design elements influence employers continued willingness to offer employer-sponsored coverage (crowd out)
7. Will Exchange provide a premium aggregation function for individuals with multiple employers who may receive premium assistance from two or more employers. How would this work

DRAFT
12/6/07

Oregon Health Fund Board -- Finance Committee
Market Design/Health Insurance Exchange Work Group
December 6, 2007

What problem are we trying to solve by creating an Insurance Exchange?

For individuals:
It is difficult for individual consumers to obtain clear and comparable information on all of the health plan options, including the high risk pool, available to them.

- Individuals are not able to use the purchasing advantages of large groups.
- Individuals are not able to benefit from other programs, e.g., health promotion and wellness, which are offered by many employers.
- Employed individuals who are not covered by their employer cannot use the tax advantages of employer-based coverage.
-

If we also include employees of small groups:

- Employees of small groups usually do not have a choice of health plans

Portability is limited, i.e., when employees move from one employer to another, then often must switch health plans.

What opportunity is created by the proposed comprehensive reform plan?

The proposed comprehensive reform plan includes a requirement for individuals to have health insurance; this will change the dynamics of the individual market. Specifically, it would bring a large group of new individuals into the market – an estimated 150-200,000 people who currently do not have coverage. In addition, there may be other reform elements, e.g., guaranteed issue and subsidies, which would affect this market. It is therefore appropriate to consider mechanisms that would enhance the ability for these consumers to shop more effectively and efficiently for health coverage.

Options

There is a range of options to consider in the design of an insurance exchange:

Level 1: At its most basic level, a health insurance exchange simply provides a mechanism to bring together a group of consumers to facilitate the purchase of health coverage from a variety of health plans.

Level 2: A more developed version of an exchange would include the following elements:

- Decision support tools and transparent information on cost, quality and service -- to support informed consumer choice
- Standardized or comparable benefits offered by health plans – to minimize unnecessary variation, facilitate comparison shopping and minimize risk skimming
- Mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment
- Market regulation to avoid an adverse risk spiral within the exchange (see discussion below)
- Assistance to employers in setting up pre-tax arrangements and administration of COBRA coverage – to provide a benefit to small employers who participate

In addition, an exchange can be a vehicle to administer subsidies for low-income individuals and employees.

Level 3: At this level, an exchange begins to operate as a purchasing pool, by using value-based purchasing strategies and support for wellness programs to drive improvements in quality, service and costs. This might imply that the exchange would select which plans could be offered rather that allowing all certified health plans to participate in the exchange.

Level 4: The exchange could operate as a stronger purchasing pool by using its size to negotiate prices with health plans and push for improved value, or actually setting rates for participating health plans.

Goals/ Design Criteria for an Exchange

- Provide an easy process for consumers to shop for coverage, e.g., clear and comparable information on the health plan options available to them.
- Allow individuals to use the purchasing advantages of large groups.
- Allow individuals to benefit from other programs, e.g., health promotion and wellness, which are offered by many employers.
- If possible, enable employed individuals who are not covered by their employer to use the tax advantages of employer-based coverage.
- Reduce administrative costs for purchasing coverage

If we also include employees of small groups:

- Provide employees of small groups with a choice of health plans
- Maximize portability so that employees are not forced to switch health plans when employees move from one employer to another.

OREGON HEALTH FUND BOARD
EXCHANGE WORKGROUP
ROSTER

2007-2008

Denise Honzel, Chair
Healthcare Consultant

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

Kerry Barnett
Executive Vice President
The Regence Group

Damian Brayko
Director, Small Group and Individual
Kaiser Permanente Northwest

Aelea Christofferson
ATL Communications, Inc.

Terry Coplin
CEO
Lane Individual Practice Assn., Inc.

Lynn-Marie Crider
Public Policy Director
SEIU Local 49

Steve Doty
President and Owner
Northwest Employee Benefits, Inc.

Chris Ellertson
Regional Health Plan Officer
Health Net Health Plan of Oregon

Jack Friedman
CEO
Providence Health Plans

Jon Jurevic
Senior Vice President, Chief Financial Officer
ODS Companies

Ken Provencher
President and CEO
Pacific Source Health Plans

Nina Stratton
Owner
The Stratton Company

Kelsey Wood
Gordon Wood Insurance

OREGON HEALTH FUND BOARD
EXCHANGE WORKGROUP
ROSTER
2007-2008

Health Policy Commission Staff

Barney Speight
Executive Director
Oregon Health Fund Board
Office: 503-373-1817
Cell: 503-856-6662
barney.speight@state.or.us

Nora Leibowitz
Acting Health Policy Commission Director
Office: 503-373-1547
Cell: 503-385-5561
nora.leibowitz@state.or.us

Alyssa Holmgren
Policy Analyst
Office: 503-373-0865
Cell: 503-302-0070
alyssa.holmgren@state.or.us

Zarie Haverkate
Communications Coordinator
Office: 503-373-1574
zarie.haverkate@state.or.us

Mailing Address:
Oregon Health Policy Commission
1225 Ferry Street SE, 1st Floor
Salem, OR 97301
Fax: 503-378-5511

Oregon Health Fund Board -- Finance Committee
Market Design/Insurance Exchange Work Group
Insurance Exchange Design Issues

What is our task? [from the Finance Committee Charter, 11/21/07]

An evaluation of and recommendations on the role an "insurance exchange" would play in a redesigned individual market, including individual choice of carrier and plan and efficient administration of subsidies to eligible Oregonians. The evaluation and recommendations will address issues including, but not limited to:

The Structure of an Exchange

- Organization of Exchange
- Governance structure
- Funding
- Ensuring sufficient enrollment/participation
- Role of brokers

Interaction between Subsidy and Exchange

- Who is offered subsidy
- Mandate use of Exchange for subsidy users?
- Products offered to those with and without subsidies
- Subsidy funding
- Coordination with the Family Health Insurance Assistance Progra

Individual Participation

- Mandatory and voluntary participants
- Minimum enrollment period requirement? Enforcement mechanism
- Portability across employers and from Medicaid to employer coverage
- Use of pre-tax dollars to purchase premiums
- Supporting consumer choice via decision support tools & cost, quality, service information

Employer Participation

- Open or limited employer participation
- Employer incentives for participation
- Encouraging/maintaining employer sponsored coverage
- Premium aggregation for employees with multiple employers
- Minimum financial participation by employer for participation?

Health Plan Participation

- Inclusion of all affordable health plan options
- Allow all willing plan or limit to select group of plans
- Integrating incentives for provider compensation, transparency, medical home, EHR
- Minimum coverage requirements?
- Development of packages that manage care, quality and cost
- Appropriate use of 125 plans

The recommendations of the Work Group on Insurance Market Changes shall be delivered to the Finance Committee on or before March 15, 2008. The Finance Committee shall consider the recommendations of the Work Group and forward final recommendations to the Board on or before April 30, 2008.

What problems are we trying to solve by creating an Insurance Exchange?

- Individuals are not able to use the purchasing advantages of large groups.
- Individuals are not able to benefit from other programs, e.g., health promotion and wellness, which are offered by many employers.
- Employed individuals who are not covered by their employer cannot use the tax advantages of employer-based coverage.
- It is difficult for individual consumers to obtain clear and comparable information on all of the health plan options, including the high risk pool, available to them, even with the help of insurance brokers and agents as well as newer web-based tools.
- There is no way to aggregate premium contributions if a person is employed by multiple employers but not eligible for employer-sponsored coverage.

What opportunities are created by the proposed comprehensive reform plan?

- The proposed comprehensive reform plan includes a requirement for individuals to have health insurance; this will change the dynamics of the individual market. Specifically, it would bring a large group of new individuals into the market – an estimated 150-200,000 people who currently do not have coverage.
- In addition, there may be other reform elements, e.g., guaranteed issue and subsidies, which would affect this market. This would require a mechanism to determine eligibility and administer subsidies efficiently on a large scale.
- An exchange can be a mechanism for enhancing consumers' ability to shop more effectively and efficiently for health coverage.

Possible Objectives for an Insurance Exchange

- Provide an easy process for consumers to shop for coverage, e.g., clear and comparable information on the health plan options available to them.
- Provide an efficient process for enrolling in health plans.
- Reduce administrative costs for purchasing coverage.
- Provide a mechanism to determine eligibility and administer subsidies efficiently and on a large scale.
- Allow individuals to benefit from the purchasing advantages of large groups.
- Allow individuals to benefit from other value-based purchasing initiatives, e.g., health promotion and wellness, which are offered by many large employers.
- Provide a mechanism to aggregate premium contributions if a person is employed by multiple employers but not eligible for employer-sponsored coverage.
- If possible, enable employed individuals who are not covered by their employer to use the tax advantages of employer-based coverage.

- Could support employers in setting up Sec. 125 plans through use of agents/brokers.
- Promote competition to design products that meet individuals' price and coverage needs.

Possible Functions of an Exchange

An insurance exchange can provide a variety of functions. We can select from this "menu" to produce a range of options for the design of an insurance exchange:

- Create a central clearinghouse for information about choices of health plans and insurance products, i.e., a mechanism to bring together a group of consumers to facilitate the purchase of health coverage from a variety of health plans.
- Design decision support tools and transparent information on cost, quality and service -- to support informed consumer choice
- Create an efficient and user-friendly mechanism for enrollment in health plans.
- Provide a mechanism to aggregate premium contributions if a person is employed by multiple employers but not eligible for employer-sponsored coverage.
- Establish standardized or comparable benefits offered by health plans – to minimize unnecessary variation, facilitate comparison shopping and minimize risk skimming.
- Design mechanisms to protect insurers who enroll high-risk members, e.g., risk adjustment or reinsurance.
- Establish market regulations to avoid an adverse risk spiral within the exchange (see discussion below)
- Establish a process to design subsidies, determine eligibility and administer subsidies for low-income individuals.
- Use value-based purchasing strategies and support for wellness programs to drive improvements in quality, service and costs.
- Promote competition in selecting which plans could be offered rather that allowing all certified health plans to participate in the exchange.
- Negotiate prices and/or discounts with health plans and push for improved value.
- Set or negotiate rates for participating health plans, or set bench mark price points.
- Provide administrative support for broker commission payments.

Other Issues

- *Who would use the exchange?* Options include:

    - All individuals getting insurance through the individual market purchase coverage through the exchange (i.e. it would be the sole mechanism for all individuals to access the health insurance market).
    - All individuals who receive subsidies purchase coverage through the exchange; voluntary use of the exchange for non-subsidized individuals.
    - Only subsidy users go through the exchange. Non-subsidized individual market purchasers would have to purchase coverage outside the exchange.

    The first option would maximize the size of the pool and may increase the purchasing power of the exchange, but it would affect the role of brokers and agents who currently serve these segments. It would also minimize the task of managing risk selection between separate pools, although this perhaps could be addressed in the other two options by ensuring that regulations regarding rating and benefits are consistent inside and outside the exchange.

- *What organization should serve as the administrator of the exchange/ purchasing pool?*

    Is it a public entity, a public service non-profit organization or a contracted private organization, or something else?

- *How would the exchange be funded?* Options include:

    - a service fee for participants (individuals and employees of small businesses).
    - a fee for small businesses whose employees participate.
    - a surcharge on insurance premiums.
    - an opportunity fee from insurers who wish to bid for inclusion on the menu of offerings within the exchange.
    - a loan from the state and/or private foundations that would be repaid over time, or that could be a five year initial capitalization.

Goals of the Oregon Health Fund Board Committees

Benefits Committee
The Benefits Committee will develop recommendations to the Board for defining a set(s) of essential health services that would be available to all Oregonians under a comprehensive reform plan. This committee will also examine subsidy levels and cost-sharing strategies that could be combined with the resulting set(s) of essential health services to create various benefit packages.

Delivery System Committee
The Delivery Committee will develop policy options and recommendations to the Board for strategies to create a high performance health system that provides timely, efficient, effective, high value, safe and quality health care for all Oregonians. The recommendations will address cost containment as well as improving health outcomes and the experience of care. The Committee will have one focused work group to develop a health care quality institute for the state.

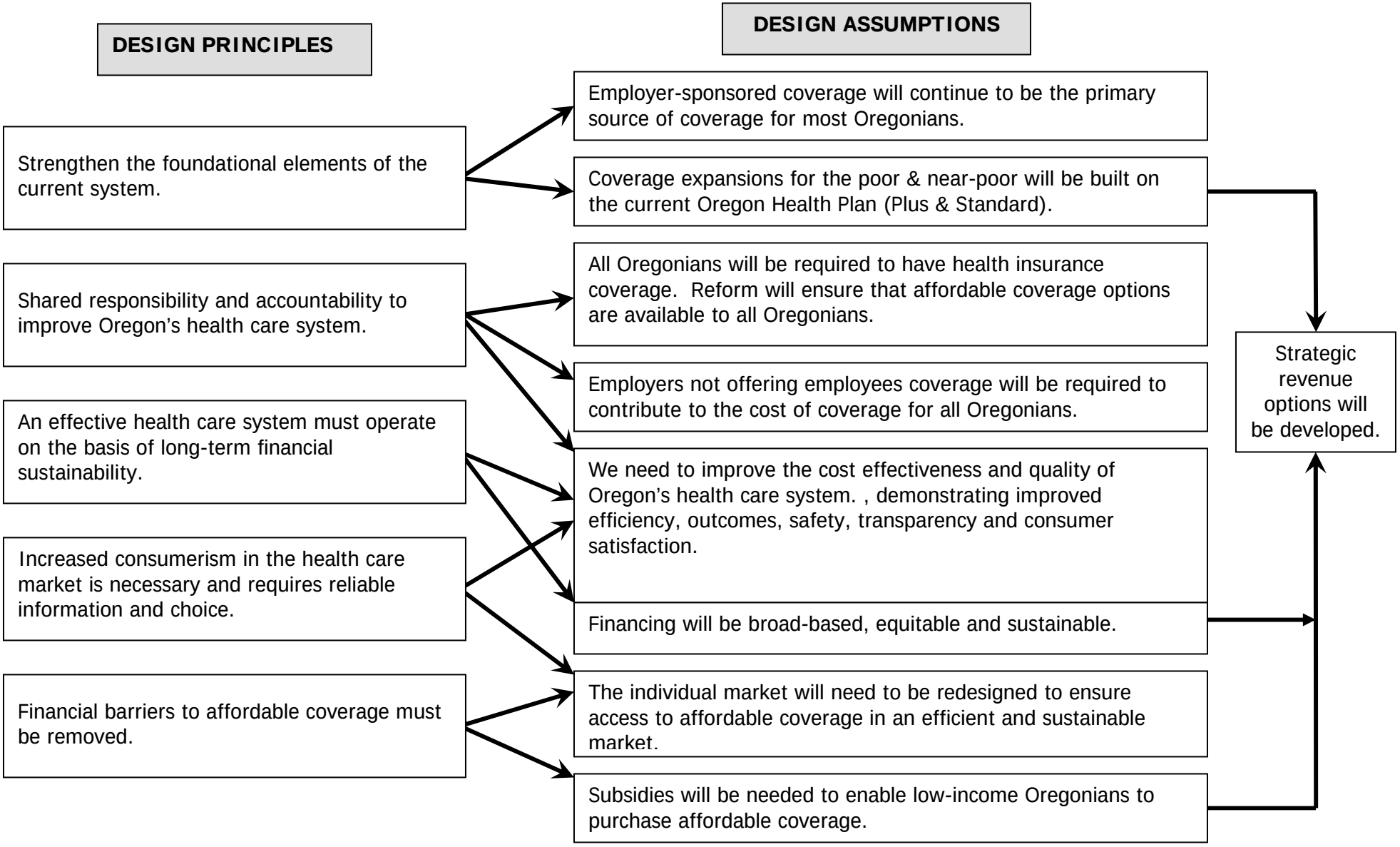
Eligibility and Enrollment Committee
The Eligibility and Enrollment Committee will develop recommendations regarding eligibility requirements and enrollment procedures for the Oregon Health Fund program. This committee will address issues related to affordability, enrollment and disenrollment procedures, outreach, as well as eligibility as it relates to public subsidies and employer-sponsored insurance.

Federal Laws Committee
The Federal Laws Committee will provide recommendations to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians.

Finance Committee
The Finance Committee will develop recommendations to the Board for strategies to finance a proposed comprehensive plan to expand access to uninsured Oregonians and to modify the operation of Oregon's non-group (individual) market to provide access to affordable coverage for individuals complying with an individual mandate for coverage. This committee will have one work group devoted to Insurance Market Changes/Health Insurance Exchange.

Health Equities Committee
The Health Equities Committee will develop multicultural strategies for program eligibility and enrollment procedures and make policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program.

OREGON HEALTH FUND BOARD
A Comprehensive Plan for Reform: Design Principles and Assumptions
11/28/07 DRAFT



Market Reform & Health Insurance Exchange
Initial "Issue Identification" List
11/28/07

NOTE: This list is not intended to be exhaustive. It is a starting place for the work of the Exchange Workgroup.

A. Regulatory Changes to Insurance Market

1. OHFB assumption: individual mandate
   i. How is a mandate administered
   ii. Exemptions
2. Will Oregon utilize guaranteed issue, maintain OMIP, or use a new process
3. What market changes will affect health plans

B. Structure of an Exchange

1. Type of entity (public/private/quasi-public, new agency/existing agency/state-sponsored private entity)
2. Governance
   i. Administered by OHFB or some other entity
   ii. If separate from OHFB, governing body (executive branch department, publicly appointed board of directors, CEO)
3. Funding
   - OHFB design assumption: Financing should be broad-based, equitable, and sustainable.
   - Health Policy Commission recommends sustainable, internally generated funding, could be supported by transaction fees, premiums, carrier membership fees, Medicaid administrative funds
4. Ensuring Viability – how to gain sufficient participation to be sustainable and influence quality and efficiency in the market

C. Individual Participation (Under discussion by Eligibility & Enrollment Committee)

1. Who will be allowed to use the Exchange (all individuals, subsidy-users, employees of small businesses, all Oregonians)
2. Which participants may enroll voluntarily
3. Will any participants be mandated to enroll, and if so which ones
4. Will enrollment periods be enforced, and if so for what period
5. Can an individual move from a Medicaid or subsidized plan into unsubsidized coverage and retain the same insurance without disruption
6. Effect on families with access to insurance for some but not all members

D. Risk Adjustment

1. Will the Exchange engage in risk adjustment for individuals enrolled through the Exchange

2. If so, how will this be accomplished (retrospective smoothing of costs among carriers/excess-loss claims subsidies to cariers/other)
3. Should the Exchange pool claims while keeping people in their own plans, with a percentage of ceded claims going to the primary insurer, the rest to a secondary insurer

E. Employer Participation

1. What employers will be able to participate in the Exchange
2. Incentives for employers to participate in the Exchange
3. Will employers be required to pay a minimum percentage of employee premiums to participate in the Exchange
4. Will the Exchange provide administrative functions for employer accessing health plans through the Exchange (such as customer service, enrollment, premium collection, billing, reconciliation, etc.)
5. Will the Exchange utilize a Third Party Administrator for some or all of these activities
6. What design elements influence employers continued willingness to offer employer-sponsored coverage
7. Will Exchange provide a premium aggregation function for individuals with multiple employers who may receive premium assistance from two or more employers. How would this work

F. Health Plan Participation

1. How to ensure inclusion of all affordable health plan options
2. Will all health insurers be allowed to participate, or will participation be limited
3. If participation is limited, how will plans be chosen
4. How to ensure meaningful variation in plan design
5. Requirements on participating plans (incentives for provider compensation, transparency, medical home, HER, etc)
6. Developing plans that manage care, quality, cost

G. Section 125 Plans

1. Will Exchange be involved with employers' use of 125 plans
2. Will some employers be required to offer 125 plans

H. Brokers

1. Role of brokers in reformed market
2. How can Exchange benefit brokers

I. Tax Treatment

1. Will individuals purchasing insurance be allowed to use pre-tax dollars to pay premiums

J. Subsidy (Under discussion by Eligibility & Enrollment Committee)

1. Who will be eligible for subsidy
2. Will subsidy be based solely on income
3. Will subsidies be available for any insurance purchase or only for insurance purchased through the Exchange

4. Are the same insurance products offered to subsidized and unsubsidized users of the Exchange
5. How will subsidies be funded (provider tax, payroll tax, other tax, general fund revenues)
    i. If Federal funds are used, what restrictions apply
6. What is the interplay between the Exchange and the Family Health Insurance Assistance Program (FHIAP)

K. Affordability Standard (Under discussion by Eligibility & Enrollment Committee)

1. Definition of Affordability