

**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 carriers/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

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 than 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.