

2019

Annual Report of the Marketplace Advisory Committee

May 31, 2020

Oregon Health Insurance Marketplace
Department of Consumer and Business Services
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About the committee

The Health Insurance Exchange Advisory Committee, known as the Marketplace Advisory Committee, advises the Department of Consumer and Business Services (DCBS) in the governance and operation of the Marketplace. As this report shows, the committee has found that many important issues of health care affordability lie outside the reach of the Marketplace's authority or the committee's scope. However, on other aspects of health coverage, the group has been able to contribute concrete and actionable advice to the Marketplace.

About this report

This annual report is required by ORS (2015) 741.004, the statute that created the committee. More than a routine filing, this report also is the committee's opportunity to highlight important health care issues.

Much of the Marketplace Advisory Committee annual report's required content is information also required of the Marketplace's own annual report. The [2019 Marketplace annual report](#) includes the following information per statute:

- Details on adequacy of assessments for reserve programs and administrative costs
- Implementation of the Small Business Health Options Program
- Number of qualified health plans offered through the exchange
- Number and demographics of individuals enrolled in qualified health plans
- Advance premium tax credits provided to enrollees in qualified health plans

An additional required component, as listed below, is included in this report:

- Feedback from the community about satisfaction with the operation of the exchange and qualified health plans (QHPs) offered through the exchange

Thank you for your interest in our committee and its insights.

Sincerely,

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Portland

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Mosaic Medical
Bend

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Ex-officio member
Insurance Commissioner and Acting
Director
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St. Charles Health System, Inc.
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Jim Houser
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Portland

Meetings

The Marketplace Advisory Committee met four times in 2019: Jan. 24, April 18, July 17, and Nov. 21. All meetings were held at the Labor and Industries Building in Salem.

A note on members and focus

The Marketplace Advisory Committee represents a wide range of health insurance stakeholders, including insurance companies, insurance agents, enrollment assisters, health care providers, small businesses, advocates, consumers, and government agencies. Throughout 2019, committee members drew on their understanding of these communities as they considered Marketplace operations.

The committee continued to focus on plan affordability and accessibility of coverage in the individual market, including access through HealthCare.gov. The committee mirrors the core mission of the Marketplace “to empower Oregonians to improve their lives through local support, education, and access to affordable, high-quality health coverage.” While the Marketplace holds this core value in high regard, the Marketplace Advisory Committee members bring their unique perspectives from the real world from the perspectives of business, assistance, and consumers.

Feedback from the community about satisfaction with the operation of the exchange and qualified health plans offered through the exchange

The Marketplace Advisory Committee concentrated on access to quality coverage for all Oregonians and state flexibilities to improve quality of service in a tumultuous health care climate throughout 2019. As multiple challenges arose, the committee was prepared to make recommendations based on the shifting environment.

Updating the technology report

Oregonians currently use HealthCare.gov, provided by the Centers for Medicare and Medicaid Services (CMS), to enroll in Marketplace plans. The fee to use HealthCare.gov is 2.5 percent of the premiums per member per month paid by Oregonians purchasing health insurance through the Marketplace. In 2016, with the committee’s concurrence, DCBS submitted a report to the legislature about a potential move to a state-based marketplace (SBM) technology as an alternative to HealthCare.gov. At the time of the initial report, HealthCare.gov was offered to Oregon for free. The state took the offer of using the HealthCare.gov technology and call center for free for plan years 2015 and 2016. The recommendation was not to proceed with a change at that time.

HealthCare.gov began charging for use of the technology in 2017 with a 1.5 percent of premium per member per month user fee, totaling \$10,670,401 (see below). These fees have increased in subsequent years:

Year	%	Total User Fee	Medical User Fee	Dental User Fee
2017	1.5	\$10,670,401	\$10,569,720	\$100,681
2018	2.0	\$16,519,260	\$16,361,566	\$157,694
2019	3.0	\$25,730,496	\$25,474,508	\$255,988

In 2018, the committee asked to re-evaluate the potential costs and benefits of implementing SBM technology after

Nevada and New Mexico issued requests for information (RFI) from technology vendors and announced plans to transition away from HealthCare.gov. The RFIs indicated that the technology costs significantly decreased since 2016, and that a state could implement a technology and call center solution at a more cost-effective rate.

The committee inquired about implementation timelines and expressed interest in moving forward with an exploration of options for Oregon, including an RFI. On April 5, 2019, the Marketplace released an RFI through ORPIN, the state procurement website. Vendors were given until April 19 to submit questions, with a deadline of May 3 for the Marketplace to post answers. The RFI closed May 31, 2019.

Marketplace staff members presented the findings at the July 2019 committee meeting, followed by a discussion. The submissions for the RFI showed that:

- There is a competitive market for SBM technology, in which vendors have products with established success in other states.
- A third-party call center is a viable option for states that is able to provide SBM-specific expertise while substantially reducing upfront planning time, costs, and overhead of implementing a call center staff and facility.
- Vendors were willing to negotiate cost structures to accommodate state budget cycles and funding capabilities.
- A vendor can implement a working solution in 18 to 24 months from contract execution, provided that the state has done enough planning before the vendor contract.

The committee evaluated the information with the following guiding principles: improved outcomes for Oregonians, better alignment with the written legislative intent for the Marketplace, Oregon ownership of the enrollment data of Oregonians, and lower overall costs to Oregonians and stakeholders. In a [letter to the DCBS director dated Sept. 23, 2019](#), the committee recommended progressing to transition to an SBM. While acknowledging the risks, the committee pointed to the key benefits:

- Oregon control over Marketplace enrollment, customer service, and operations.
- Giving Oregon the ability to implement state-specific innovations and enrollment timelines that are currently within its authority, but impossible to implement because of incompatibility with HealthCare.gov. These would include premium assistance programs, lengthening open enrollment periods, and Medicaid buy-in concepts.
- Reduction in, and predictability of, costs of a Marketplace enrollment technology for insurance carriers and Oregonians paying insurance premiums.
- Stakeholder (carriers, agents, assisters, and other agencies) benefits, including tools to directly interact with the technology, as well as the ability for the Marketplace to implement stakeholder ideas and improvements to their experience.

Ultimately, the reasons for a move to SBM technology center around returning control of Oregon's Marketplace enrollment operations back to Oregon. Though outside of the 2019 scope of this report, the COVID-19 pandemic in 2020 has illustrated how important this control is:

- Twelve SBM states opened special enrollment periods (SEP) starting in March and April to allow residents who had not selected a plan during open enrollment to get coverage through their marketplaces.
- This is an option Oregon has been unable to exercise, despite its inherent authority to do so. We are constrained by whatever the Centers for Medicare and Medicaid Services decides to do with HealthCare.gov, regardless of the Marketplace's authority.

The committee continues to recommend that Oregon proceed towards its own SBM technology, with all possible haste that due diligence will allow. As of publication of this report, Nevada has successfully completed its transition to a full SBM. Maine, New Mexico, New Jersey, Pennsylvania, and Virginia are currently in the process of completing the transition, as well.

Senate Bill 250: Oregon statute revisions to mirror the Affordable Care Act

January brought concerns about Public Charge impacts on Oregonians' access to coverage, primarily on Medicaid rules. In addition, the committee evaluated *Texas v. Azar* and the potential implications on 2020 plan selection. These risks were deemed low for Marketplace-eligible consumers for the upcoming plan year, but remain on the radar of the committee. However, to remain diligent in ensuring access to coverage, the Division of Financial Regulation

introduced SB 250, which is intended to mirror provisions of the Affordable Care Act (ACA) in Oregon statutes, including:

- Protections for people with pre-existing conditions
- Mental health parity requirement clarifications for qualified health plans (QHP)
- Prohibition of certain types of discrimination, mirroring ACA section 1557
- Establishment of authority to create a state risk adjustment program if needed
- Changes to health reimbursement arrangements to align with federal provisions
- Allowance for more than one standard bronze plan to allow carriers more flexibility with Health Savings Account (HSA) plans
- Clarification of coverage across state line in specific circumstances

The committee is largely in agreement with SB 250 and expressed support for including a state mandate for coverage to ensure risk pools remain as large as possible and, in turn, help keep premiums low. This is a discussion that the committee is interested in having. SB 250 was passed in June 2019, effective June 1, 2020, without a state mandate. The committee is interested in participating in future conversations regarding a state mandate.

SB 889: Statewide Health Care Cost Growth Target

In 2019, the Oregon Legislature passed SB 889, which established the Statewide Health Care Cost Growth Benchmark program within the Oregon Health Authority to ensure statewide health care costs incurred through Medicaid, commercial insurance, and Medicare grow at a sustainable level. To achieve this, the program is responsible for establishing a benchmark for the annual rate of growth of health care expenditures across all payers and providers in Oregon.

Although the state has done a good job in meeting targets with state health programs (such as Medicaid) and public employee programs, the commercial market poses significant challenges. Health care is growing at an unsustainable rate of about 6.5 percent, with out-of-pocket costs growing much more quickly. These costs lessen money from wages and retirement programs.

Oregon Gov. Kate Brown appointed an 18-person group, which several committee members are a part of: Kraig Anderson, Ken Provencher, Shannon Saldivar, and Jenn Welander, along with Oregon Insurance Commissioner Andrew Stolfi. The committee is looking forward to SB 889 reports and recommendations for future alignment opportunities for the Marketplace.

Plan design

Throughout 2019, the committee discussed ways to modify plan design to improve Oregonians' access to care. A major shift in plan design for 2020 is to ensure Bronze plan enrollees are able to access benefits with co-pays before deductibles are met, including primary care visits. Bronze plans are typically the least expensive plans per month, but have the highest deductibles. This change to the Bronze plan design brought an increase of about 7 percent of enrollees selecting Bronze plans, to 62,350 out of 145,264 total enrollees (42.9 percent of the total). The committee supports continuing the conversation to explore ways to further improve access to benefits. More information about Bronze plan management can be found starting on Page 6 of the [Marketplace Annual Report](#).