Agenda

Oregon Health Insurance Marketplace Advisory Committee Meeting
Thursday, April 7
1 to 4 p.m. – Room 260
Labor and Industries Building
350 Winter St. NE
Salem, OR 97301

You may listen in to the meeting at the following number:
Phone: (712) 770-4010 Participant Code: 869760

1:00 – 1:15	Welcome and introductions	Patrick Allen
1:15 – 1:45	Marketplace overview	Patrick Allen and Berri Leslie
1:45 – 2:00	Election of chair and vice-chair	Call for nominations
2:00 – 2:30	Review and consensus for bylaws	Chair
2:30 – 3:00	Assessment Rule Discussion	Chair
3:00 – 3:45	Basic health plan work group planning and discussion	Chair
	Public comment/discussion	Chair

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Oregon Health Insurance Marketplace

Advisory Committee Roster

- ex-officio - **Patrick Allen**, Director, Department of Consumer and Business Services
- ex-officio – **Mark Fairbanks**, Chief Financial Officer, Oregon Health Authority

- **Shonna Butler**, life and health insurance broker, Tomlin Benefit Planning, Inc., Eugene
- **Cynthia Condon**, marketplace enrollee representative, Salem
- **Joe Enlet**, organizing director, COFA Alliance National Network, Portland
- **Joe Finkbonner**, executive director, Northwest Portland Area Indian Health Board, Portland
- **Dan Field**, senior director, Community Benefit and External Affairs, Kaiser Permanente Northwest, Portland
- **Jim Houser**, owner, Hawthorne Auto Clinic, Portland
- **Lora Lawson**, chief nursing officer, Curry Health Network, Gold Beach
- **Sean McAnulty**, Project Access Now, Portland
- **Jesse O'Brien**, policy director, OSPIRG, Portland
- **Ken Provencher**, CEO, PacificSource Health Plans, Springfield
- **Shanon Saldivar**, insurance agent, Revell Coy Insurance, The Dalles
- **Claire Tranchese**, training development manager, Oregon Primary Care Association, Portland
- **Maria Vargas**, outreach manager, Valley Family Health Care, Ontario

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Health Insurance Marketplace Advisory Committee
2016 Meeting Schedule

April 7, 2016 – Labor and Industries Building, Room 260 from 1 to 4 pm
350 Winter St. NE Salem 97301

May 9, 2016 – Wildhorse Resort and Casino, Palouse Room from 8:30 to 11:30 am
46510 Wildhorse Blvd Pendleton, 97801

June 9, 2016 – WorkSource Oregon, Eugene from 1-4 pm
2510 Oakmont Way Eugene, 97401

September 14, 2016 – Location TBD from 1-4 pm
Bend

November 9, 2016 – Location TBD from 1-4 pm
Portland

For questions, contact:

Victor Garcia, Committee Liaison
971-283-1878 | victor.a.garcia@oregon.gov

Oregon Health Insurance Marketplace

Presentation for

The Health Insurance Exchange Advisory Committee

April 2016

by

Patrick Allen, Director
Department of Consumer and Business Services

Berri Leslie, Administrator
Oregon Health Insurance Marketplace

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Oregon's Marketplace

What we provide for Oregonians:

- Access to a range of **qualified health plans**/meaningful choice to help individuals and families find the right coverage for them.
- Access to **subsidies** that help pay for premiums and out-of-pocket costs.
- **Information** to help consumers learn about health care coverage.
- **Consumer assistance** through a call center, staff in the field, and trained and certified agents and community partner organizations.

Transition from Cover Oregon

Fall 2014:

- DCBS learns about legislative concept to close Cover Oregon and move functions to DCBS.
- DCBS begins high-level planning to prepare for the possibility.

December 2014:

- Legislation appears likely to pass.
- DCBS and Cover Oregon meet to develop a transition plan.
- DCBS works with Cover Oregon to learn about the marketplace.

March 2015:

- SB 1 enacted.

Senate Bill 1

- Upon passing, dissolved the Cover Oregon Board and granted its authority to DCBS director.
- Transferred functions and duties of Cover Oregon to DCBS on June 30, 2015, only 3 months after bill enactment.
- Maintained Oregon's status as a state-based marketplace.
- Created Health Insurance Exchange Advisory Committee to advise DCBS director.

Legislative Oversight

SB 1 also **restored full legislative oversight** and control of the Marketplace:

- ✓ Through the **budget process**, the legislature has control over program/staffing levels/fund balances.
  - ✓ Position control
  - ✓ Expenditure authority
  - ✓ Fee ratification
  - ✓ Budget notes

Legislative Oversight (cont.)

DCBS must also:

- ✓ **Report to the legislature** annually and, during the 2015-2017 biennium, every time the interim Joint Ways and Means Committee and committees related to health care meet.

- ✓ **Notify every legislator to spend over $1 million on technology**, and all technology projects must go through DAS and CIO processes/approvals.

What transferred to DCBS

Cover Oregon Functions	HealthCare.gov	DCBS
Oversight and administration		X
Finance (budgeting/accounting/procurement)		X
Policy/rulemaking		X
Plan management		X
Outreach and education		X
Navigator program		X
Stakeholder engagement		X
Reporting/auditing		X
Small Business Health Options Program (SHOP)		X
Call Center	X	X
Individual eligibility	X	
Individual enrollment	X	
Individual appeals and grievances	X	
Individual information technology platform	X	

Other Transitional Work

As part of the transition, DCBS had to handle some one-time work related to the 2014 plan year:

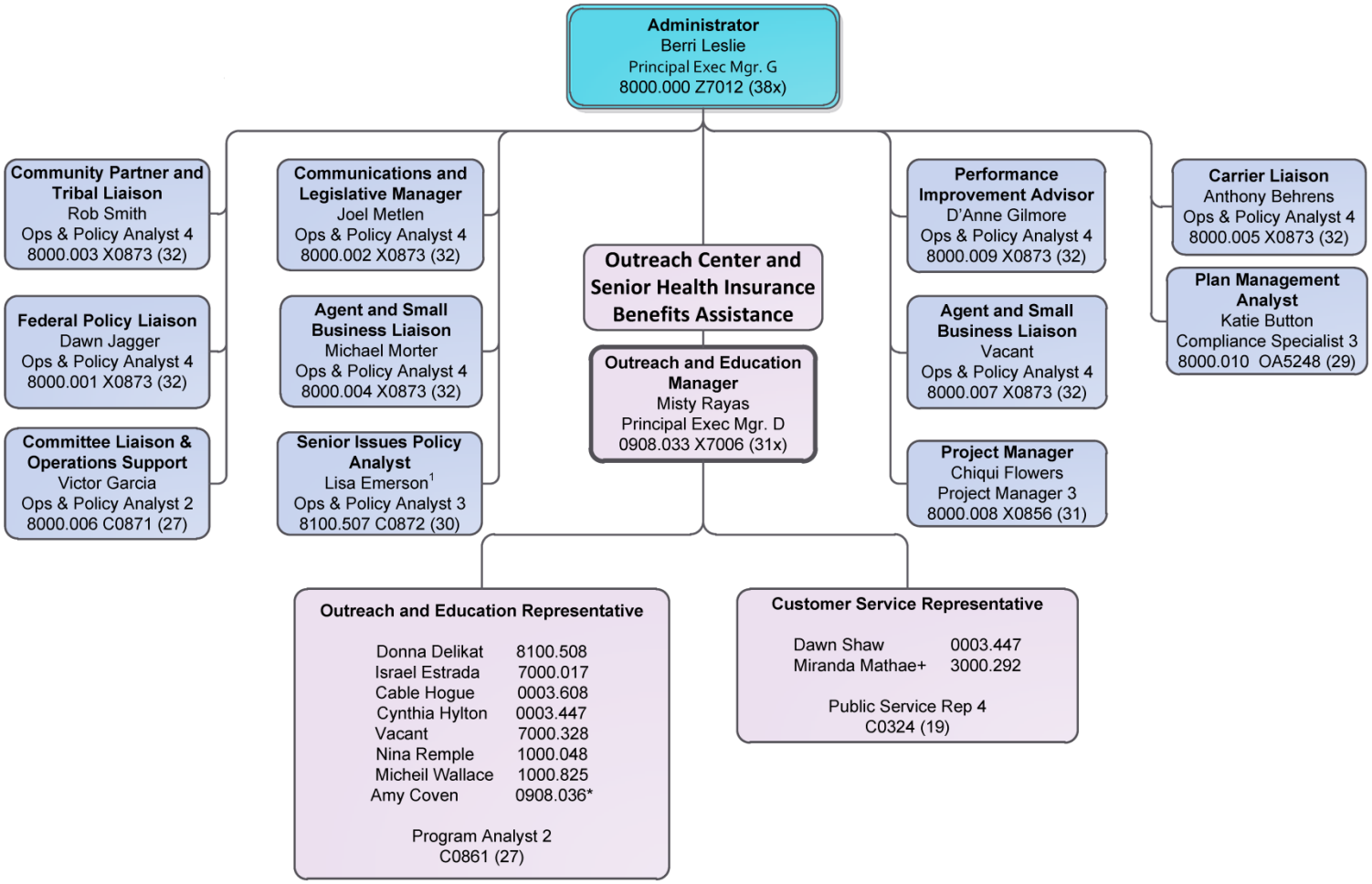
- ✓ **2014 IRS Form 1095-A support**
  - Issuing and making corrections to tax forms for consumers.
- ✓ **2014 APTC error support**
  - Providing a mechanism for anyone who had issues with Cover Oregon's APTC calculations.
- ✓ **2014 Appeals and grievances**
  - Handling any outstanding appeals or grievances related to eligibility and enrollment issues.
- ✓ **2014 eligibility/enrollment**
  - Winding down eligibility and enrollment activities (life changes, etc.) related to 2014 plans.
- ✓ **2014 agent commissions**
  - Making sure agents received commission payments for enrolling customers.
- ✓ **Cover Oregon IT systems decommissioning and data archiving**
  - Winding down and archiving according to all federal and state rules.

The Marketplace at DCBS

- Started operating **July 1, 2015**.
- **DCBS director responsible/accountable** for the Marketplace, with feedback and input from Advisory Committee.
- **A smaller, leaner organization** due to economies of scale/cost savings from shared services: 24 current employees vs. more than 100 at Cover Oregon in December 2014
- Has its own fund, **funded through a per member per month fee** on plans sold through the exchange.
- **Works hand-in-hand with stakeholders**, including OHA, CMS, IRS, agents, insurers, etc.
- **Separate from the Division of Financial Regulation** (formerly Oregon Insurance Division)
- **Integrating the Senior Health Insurance Benefits Assistance program**, which provides support for Oregonians on Medicare, to help provide better service to Oregonians.

The Marketplace at DCBS

Oregon Health Insurance Marketplace



The Advisory Committee

- ✓ The Advisory Committee **provides guidance and feedback** on issues affecting the marketplace such as outreach, customer feedback, and insurance plan affordability.

- ✓ It consists of **13 members** appointed by the Governor and confirmed by the Oregon Senate on Feb. 15, representing insurers, insurance producers, navigators, health care providers, businesses, consumer advocacy groups, enrollees in health plans, and medical assistance agencies.

- ✓ The Department of Consumer and Business Services director and Oregon Health Authority director will be **ex-officio members**.

- ✓ The committee will hold open meetings that provide **a forum for public discussion.** It will begin meeting in **April 2016.**

Budget Structure

- The Marketplace has **its own, separate fund**, not dependent on federal grants or the state general fund
- It is currently funded through **a per member per month fee of $9.66 for medical plans and $0.97 for dental plans** bought through the Marketplace
- For 2017, the proposed **per member per month fee will be $6.00 for medical plans and $0.57 for dental plans**
- The budget includes **continued cost sharing with OHA** for shared licenses

Revenue

- Revenues have been **higher than expected**.
  - November 2015 Interim reporting biennial estimate $20.9 million in per member per month (PMPM) revenue
  - Current biennial estimate with proposed rate decrease is $24.9 million in PMPM revenue
  - 18% increase
- Higher revenues are due to an **increase in expected enrollment** as a result of a successful open enrollment campaign, other factors
- Continued leverage of shared licensing costs with OHA

Expenditures

- Original biennial estimate $32 million
- January 2016 biennial estimate $24 million
- Current biennial estimate **$26 million**
  - Increase from January due to contractual obligations related to transitional work (e.g. 1095A support)
- Potential future costs:
  - SHOP
  - Additional Centers for Medicare and Medicaid Services (CMS) Security requirements

Ending Fund Balance

- Due to the differences in revenues and expenses from initial projections, **the ending fund balance is higher than anticipated.**
- Currently the maximum allowable fund balance is equal to **6 months of expenditures**.
- DCBS is proposing administrative rules which defines the process for rebating excess fund balance.
- Current ending biennial fund balance for June 2017 is **approximately 14 months of expenditures**.

Budget Updates

- We based forecasts on best information at the time, under tight deadlines, with the intention of **coming back to revise as more information became available**.
- DCBS **requested changes related to staffing and outreach and education.**
- DCBS is currently **assessing the costs of technology platforms**, including a SHOP platform, to determine impacts on the fund balance.

Technology System

- CMS will charge a fee of **1.5% of premiums** for HealthCare.gov for plan year 2017 and **3% of premiums** in 2018, about $13 million/year. This fee is in addition to the fee the state currently charges to cover all other Marketplace costs.

- To make sure HealthCare.gov is the best use of public dollars, DCBS released **an RFP to gather information and compare costs/functionality** of HealthCare.gov to other off-the-shelf, systems.

- DCBS received **four proposals**, which the selection committee is currently reviewing and scoring. We will then prepare an **analysis of the options** for the legislature.

2016 Open Enrollment

- Open enrollment occurred between **Nov. 1 and Jan 31**. It was the time of year when Oregonians could **sign up, renew, or change plans**.
- We ran an aggressive, **targeted outreach campaign** to provide information, resources, and assistance to Oregonians.
- **147,109 Oregonians enrolled**, which is **35,000 more** than peak enrollment for the 2015 plan year. **71%** of enrollees were receiving tax credits averaging **$250** per month.
- Oregon is **1st among HealthCare.gov states** for highest percentage of enrollment compared to last year and **1st among HealthCare.gov states** for enrolling subsidy eligible consumers.
- We are using the results from this year's campaign **to inform our planning for next year**.

2016 Outreach Campaign

- The goals of the 2016 campaign were:
  - **Drive enrollment** in the Marketplace, especially for subsidy eligible Oregonians
  - Encourage customers to **actively shop** instead of auto-reenroll
  - **Build trust** with customers and stakeholders
- The campaign was **highly targeted** and included:
  - Outreach to Marketplace and subsidy eligible Oregonians, the remaining uninsured, minority audiences, and small businesses
  - In the field outreach and education, including enrollment events and meetings
  - Paid media focused on digital advertising
  - Spanish and Russian language advertising
  - Earned media
  - An agent storefront program and a consumer assistance navigator program
  - Materials and support for agents and partners
- The cost of the campaign was just over **$2 million**, on par with what other states spend.
- **The 2016 campaign has been an overall success** based on qualitative measures, including enrollment numbers, media analytics, and customer and stakeholder feedback.

2016 Campaign Results

The 2016 campaign helped **drive enrollment and reach target audiences**:

- More than **147,000 Oregonians enrolled**, an increase of 35,000 people or 31% over last year, **more than any other HealthCare.gov state**
- More than **147 million ad impressions** served to Oregonians, resulting in a click-through rate of .15%, **almost twice the industry average** of .08%
- More than **353,000 website sessions** on OregonHealthCare.gov
- **90 earned media placements** in publications with **circulation in the millions** resulting from our press releases and reporter outreach, in a year when most states struggled to get media coverage
- More than **16,500 customers served by our 24 storefront agents**, including 11,724 existing customers and 4,655 new customers.
- Almost **3,000 customers served by our 4 community partner organizations**
- More than **1,600 phone calls and 300 emails** from consumers handled by our Outreach Center and **67 events and informational meetings** staffed by DCBS

2017 Outreach Campaign

- We are using the data from our 2016 campaign to inform our planning for next year. **Detailed planning began in March and continue through August.**
- For 2017, we plan on **a similar campaign to 2016 to replicate and build on this year's successes.**
- Like the 2016 campaign it will be **highly targeted, based on research and data** about key audiences, including the remaining uninsured.
- Due to the similarity to the 2016 campaign, we expect a need for another $2 million and need authority for an **increase of spending authority of $1.7 million**.

2016 Legislation

Two bills came out of the 2016 legislative session that impact the Marketplace:

1. **HB 4071:** establishes a COFA Premium Assistance Program administered by DCBS to provide financial assistance with health care premiums and out-of-pocket costs for Pacific Islanders legally residing in Oregon under Compact of Free Association.

2. **HB 4017**: 4017 requires DCBS in collaboration with OHA and a stakeholder advisory group to create a blueprint for a Basic Health Program and gives DCBS sole authority for waivers for state innovation, including alternative approaches for achieving the objectives of the Basic Health Program.

Questions?

MARKETPLACE ADVISORY COMMITTEE BYLAWS

WHEREAS, Senate Bill 1, a legislative act of 2015 creating the Oregon Health Insurance Marketplace within the Oregon Department of Consumer and Business Services, was enacted by the Oregon Legislative Assembly and signed into law by the governor on March 6, 2015;

WHEREAS, under the governing legislation, the governor has appointed the members of the Marketplace Advisory Committee; and

WHEREAS, the members of the Marketplace Advisory Committee acknowledge their responsibility to provide advice in good faith, in the best interest of Oregonians, and in accordance with Senate Bill 1 and other law;

NOW, THEREFORE, BE IT RESOLVED that the Marketplace Advisory Committee hereby adopts its bylaws for the Marketplace Advisory Committee of the Oregon Health Insurance Marketplace, attached as Exhibit A.

I HEREBY CERTIFY that the foregoing resolution was adopted on this [X]th day of [MONTH] 2016, by the Marketplace Advisory Committee of the Oregon Health Insurance Marketplace.

[NAME]
Committee Chairperson

BYLAWS OF THE MARKETPLACE ADVISORY COMMITTEE

ARTICLE 1. DEFINITIONS

- **ACA:** Patient Protection and Affordable Care Act signed into law by President Barack Obama on March 23, 2010.
- **Marketplace Advisory Committee:** The committee is the advisory body established by the 2015 legislation creating the Oregon Health Insurance Marketplace.
- **Business:** As defined in Government Ethics statute (ORS 244.020), business means any corporation, partnership, proprietorship, firm, enterprise, franchise, association, organization, self-employed individual, and any other legal entity operated for economic gain, but excluding any income-producing not-for-profit corporation that is tax exempt under section 501(c) of the Internal Revenue Code with which a public official or a relative of the public official is associated only as a member or board director or in a non-remunerative capacity.
- **Actual conflict of interest:** As defined in ORS 244.020, means any action or any decision or recommendation by a person acting in a capacity as a public official, the effect of which would be to the private pecuniary benefit or detriment of the person or the person's relative or any business with which the person or a relative of the person is associated unless the pecuniary benefit or detriment arises out of circumstances described in ORS 244.020 (12).
- **Potential conflict of interest:** As defined in ORS 244.020, means any action or any decision or recommendation by a person acting in a capacity as a public official, the effect of which could be to the private pecuniary benefit or

detriment of the person or the person's relative, or a business with which the person or the person's relative is associated, unless the pecuniary benefit or detriment arises out of the following:

(a) An interest or membership in a particular business, industry, occupation, or other class required by law as a prerequisite to the holding by the person of the office or position.

(b) Any action in the person's official capacity which would affect to the same degree a class consisting of all inhabitants of the state, or a smaller class consisting of an industry, occupation, or other group including one of which or in which the person, or the person's relative or business with which the person or the person's relative is associated, is a member or is engaged.

(c) Membership in or membership on the board of directors of a nonprofit corporation that is tax-exempt under section 501(c) of the Internal Revenue Code.

- **Executive session:** As defined in ORS 192.610 (2): Any meeting or part of a meeting of a governing body that is closed to certain people for deliberation on certain matters.
- **Fiscal year:** The fiscal year of the Marketplace begins July 1 of each year and ends June 30 of the next year.
- **Biennium:** The state fiscal or budgetary cycles begins July 1 of every odd-numbered year and ends June 30 two years later. For example, the 2015-17 biennium begins July 1, 2015, and ends June 30, 2017.
- **CCIIO:** U.S. Department of Health and Human Services; Centers for Medicare and Medicaid Services; Center for Consumer Information and Insurance Oversight.
- **Public Meeting Law:** ORS 192.610-192.690 are the state statutes governing public meetings. The committee must comply with these statutes.

ARTICLE 2. PURPOSE AND POWERS

Section 1: The Committee will advise the director of the Department of Consumer and Business Services on development and implementation of the policies and operational procedures governing the administration of the Marketplace.

Section 2: The Oregon Health Insurance Marketplace is an independent unit within the Oregon Department of Consumer and Business Services.

Section 3: As set forth in the legislation, the duties of the Marketplace Advisory Committee are to provide advice on all of the following:

- The amount of the assessment imposed on insurers under ORS 741.105
- The implementation of a Small Business Health Options Program in accordance with 42 U.S.C. 18031
- The processes and procedures to enable each insurance producer to be authorized to act for all of the insurers offering health benefit plans through the Marketplace
- The affordability of health benefit plans offered by employers under section 5000A(e)(1) of the Internal Revenue Code
- Outreach strategies for reaching minority and low-income communities
- Solicitation of customer feedback
- The affordability of health benefit plans offered through the Marketplace

Section 4: As established in the legislation, the committee will provide annual reports to the Legislative Assembly, in the manner provided in ORS 192.245, of the findings and recommendations the committee considers appropriate, including a report on all of the following:

- 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 Marketplace
- Number and demographics of individuals enrolled in qualified health plans
- Advance premium tax credits provided to enrollees in qualified health plans
- Feedback from the community about satisfaction with the operation of the exchange and qualified health plans offered through the Marketplace

Section 5: The committee may hire experts to help discharge its duties, subject to the approval of the director of the Department of Consumer and Business Services. All expenses of the committee will be paid out of the Health Insurance Marketplace Fund.

ARTICLE 3. MARKETPLACE ADVISORY COMMITTEE

Section 1: The committee consists of 15 members, consisting of two ex-officio voting members (the director of the Oregon Health Authority and the director of the Department of Consumer and Business Services) and 13 members appointed by the governor and confirmed by the Senate.

Section 2: Committee member terms of office are two years, with no more than two consecutive terms of service.

Section 3: Appointed committee members serve at the pleasure of the governor.

Section 4: The committee may create policies that describe the governance structure, decision-making processes, and other relevant committee processes. Such policies may be outlined in a committee policy manual.

Section 5: Committee members serve without compensation but are entitled to travel expenses as outlined in ORS 292.495.

Section 6: Rules of Order

A. The committee will conduct its business through discussion, consensus building, and informal meeting procedures.

B. The chairperson may, from time to time, establish specific procedural rules of order to assure the orderly, timely and fair conduct of business. The chairperson may refer to the most recent edition of Robert's Rules of Order for guidance.

Section 7: Quorum and Voting Rights

A. Quorum – A majority of the voting members of the committee constitutes a quorum for the transaction of business or other action, so eight voting members constitute a quorum of the committee. The continued presence of a quorum is required for any official vote or action of the committee throughout an official meeting. Less than a quorum of the committee may receive testimony.

B. Voting – All official actions of the committee must be taken by a public vote. On all motions or other matters, a voice vote may be used. At the discretion of the chairperson or at the request of a committee member, a show of hands or roll-call vote may be conducted. Proxy votes are not permitted. The results of all votes and the vote of each member by name must be recorded. Abstaining votes are recorded as abstention. At least eight concurring votes must be cast in order to pass or reject a motion.

Section 8: Conflict of Interest

Actions of the committee are subject to the Oregon government ethics law, including requirements for declaring conflicts of interest and potential conflicts of interest.

ARTICLE 4. COMMITTEE MEETINGS

Section 1: Meetings of the committee are open to the public and held in accordance with the state's public meeting law.

Section 2: A majority of the voting members of the committee constitute a quorum for the transaction of business. Committee members may participate in meetings by telephone or videoconferencing. Committee members participating by such means are counted for quorum purposes, and their votes are counted when determining the actions of the committee.

Section 3: At the discretion of the chairperson, special or emergency meetings of the committee may be convened in order to conduct official business between regularly scheduled meetings. In the absence of the chairperson or vice chairperson, a majority of committee members may call a meeting. In accordance with ORS 192.660, the chairperson may convene an executive session during a regular, special, or emergency meeting.

Section 4: In accordance with ORS 244.120, committee members must publicly announce the nature of any conflict of interest or potential conflict of interest before participating in any official action on the issue giving rise to the conflict of interest.

ARTICLE 5. SUBCOMMITTEES

Section 1: The committee may establish subcommittees, technical committees, or workgroups as needed to discharge its duties.

ARTICLE 6. HEALTH INSURANCE MARKETPLACE FUND

Section 1: The Oregon Health Insurance Exchange Fund is established in the state treasury, separate and distinct from the General Fund. Interest earned by the fund will be credited to the fund.

Section 2: The Oregon Health Insurance Marketplace Fund consists of money received by the Department of Consumer and Business Services under ORS 741.001 to 741.540 and money transferred by Senate Bill 1. The money in the fund is continuously appropriated to the department.

Section 3: The committee advises the director of the Department of Consumer and Business Services on the amount of assessment imposed on insurers under ORS 741.105. The committee will provide an annual report to the Legislature on the adequacy of the assessments for reserve programs and administrative costs.

ARTICLE 7. REPORTING

Section 1: As established by the legislation, the committee will provide annual reports to the Legislative Assembly, in the manner provided in ORS 192.245, of the findings and recommendations the committee considers appropriate, including a report on all of the following:

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

ARTICLE 8. INDEMNIFICATION

Section 1: The following statutes apply to the members of the committee:

- **30.260 - 30.300:** Definitions for statutes related to "Tort Actions Against Public Bodies"
- **30.310:** Actions and Suits By Governmental Units
- **30.312:** Actions by Governmental Units Under Federal Antitrust Laws
- **30.390:** Satisfaction of Judgment Against Public Corporations
- **30.400:** Actions By and Against Public Officers in Official Capacity

ARTICLE 9. AMENDMENT TO BYLAWS

Section 1: The committee, or any member of the committee, may propose amendments to the bylaws. Committee members must receive proposed amendments no less than seven days before any regularly scheduled, special, or emergency meeting. Proposed amendments must be approved by a quorum vote.

Explanation for Amendment to OAR 945-030-0020

ORS 741.105 gives the Marketplace the right to collect a fee from insurers for selling products through the federally facilitated marketplace. The statute also allows the Marketplace to retain six month's worth of future operating expenses. Amounts exceeding six month's of future operating expenses must be returned to participating Marketplace insurers. The statute allows the Marketplace to return the funds by crediting an insurer's share of the refund against the amount the carrier pays in future assessments.

OAR 945-030-0020 currently requires the Marketplace to calculate the amount of any excess funds by subtracting 25% of the total 2-year budget from the fund balance at the end of each calendar year. For example, if the fund balance on December 31, 2015 was $1 million and the budget for the 2015 to 2017 biennium is $2 million, the excess funds that the Marketplace must credit to carriers against future assessments equals $500,000. ($1,000,000 - .25 x $2,000,000 = $1,000,000 - $500,000 = $500,000).

The problem with the rule as it is written is that it requires the Marketplace to calculate expenses across different budget cycles. For instance, in the example above, the refund is calculated based on six months of the previous biennium (January 1, 2015 to June 30, 2015) and six months of the new biennium (July 1, 2015 to December 31, 2015). The amendment to OAR 945-030-0020 addresses this problem by requiring that the calculation be based on the fund balance at the end of each biennium rather than the end of each calendar year.

By focusing on the fund balance on June 30 of every odd year (the end of each biennium), the rule captures any true excess fund balance because the amount of money (if any) remaining on June 30 of each odd year reflects the actual amount of money the Marketplace is over or under budget. For example if at the end of the 2015 to 2017 biennium (June 30, 2017), the fund balance is $1 million, it means the Marketplace collected $1 million more than it had in expenses for the budget cycle. If the budget for the new biennium (July 1, 2017 through June 30, 2019) is $4 million, the department would retain the entire $1 million because it represents no more than six month's worth of operating expenses. ($1,000,000 – ($4,000,000/4) = $1,000,000 - $1,000,000 = $0, and $0 is refunded.)

The amendment to the rule also clarifies that the Marketplace must refund excess funds to participating carriers over the biennium. According to the amendment, credits are applied on a pro rata basis in equal installments. However, if the director finds that spreading the payments out over the biennium would jeopardize the solvency of an insurer, the Marketplace may use any other reasonable method to credit the insurer any funds that are due.

STATEMENT OF NEED AND FISCAL IMPACT WORKSHEET

For internal agency use only. Not a valid filing form.

Department of Consumer and Business Services, Oregon Health Insurance Marketplace — OAR 945-030-0020

Agency and Division Name — Administrative Rules Chapter Number

RULE CAPTION

Calculation and application of a fund balance credit

In the Matter of:

The amendment of OAR 945-030-0020.

Stat. Auth.: ORS 741.002 and ORS 741.005

Other Authority: N/A

Stats. Implemented: ORS 741.005

Need for the Rule(s):

The amendment to OAR 945-030-0020 is necessary to synchronize the calculation and application of any fund balance credit with the Department of Consumer and Business Services's two-year budget cycle.

Documents Relied Upon, and where they are available:

ORS 741.002 and ORS 741.005, available on this web page: https://www.oregonlegislature.gov/bills_laws/ors/ors741.html.

Fiscal and Economic Impact:

The Department of Consumer and Business Services may save resources by synchronizing the calculation and credit of credits with the agency's two-year budget cycle.

An issuer that is otherwise eligible for credits against the imposed assessments will lose those credits if the issuer ceases to offer products through the Oregon Health Insurance Marketplace.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

The Department of Consumer and Business Services may save resources by synchronizing the calculation and credit of credits with the agency's two-year budget cycle. There should be no impact on local governments and little to no impact on the public.

2. Cost of compliance effect on small business (ORS 183.336):
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

0. This rule does not directly impact small businesses.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

0. This rule does not directly impact small businesses.

c. Equipment, supplies, labor and increased administration required for compliance:

0. This rule does not directly impact small businesses.

How were small businesses involved in the development of this rule?

An advisory committee that included representatives of small businesses reviewed the rule and provided input.

Administrative Rule Advisory Committee consulted? Yes or No?
If not, why not?

Yes.

945-030-0020 (**Amended**)

Establishment of Administrative Charge Paid by Insurers

(1) After consulting with the **advisory committee**[*Advisory Committee*] created by Section 13 of 2015 Senate Bill 1, **the** Marketplace[*staff*] will annually provide a[Report on Administrative Charges] **report on administrative charges** to the Director of the Department of Consumer and Business Services[*(Director)*].

(2) The report will be posted on the Marketplace's website for public review and comment.

(3) At a minimum, the report will include**:**

(a) A projection of Marketplace operating expenses**,** [*(*]including the Marketplace**'s** share of[*DCBS*] **the department's** shared services expenses[,] and operating expenses borne by the Marketplace and reimbursed by another agency**,**[*)*] based on[DCBS] **the department's** budgets, assuming for this purpose that the operating expenses in any actual or expected biennial budget are distributed evenly over the biennium;

(b) A projection of Marketplace enrollment for the next calendar year; and

(c) A proposed administrative charge for the next calendar year.

(4) The[Department] **department** will hold a public hearing on a proposed administrative charge.

(5) No later than the end of the first quarter of a calendar year the Director shall amend or approve an administrative charge for the next calendar year.

(6) Any administrative charge adopted by the Director shall be established in rule.

(7) The administrative charge shall be expressed as a per member per month figure.

(8) The annual administrative charge assessed by the Marketplace shall not exceed the limits set forth in ORS 741.105(2) on the premium or other monthly charge based on the number of enrollees receiving coverage in qualified health plans or stand alone dental plans through the Marketplace during the month of December preceding the report.

(9) **By the 30th day of September of every odd year, [***The*] **the department shall:**

(a) Calculate the maximum amount[*permissible*] **of funds that the department may hold** under ORS 741.105**(3)(b)**[*will be calculated*] by **calculating**[*comparing the*]**:**

(A) The Marketplace's fund balance **as of the 30th day of the immediately preceding June[** *at the end of each December with*] **minus:**

(B) One-fourth of the Marketplace's budgeted operating expenses **for the two-year period beginning on the first day of the immediately preceding July and ending on the 30th day of June of the following odd year;**[*for the following six-month period (calculated as one-fourth of the budgeted operating expenses for the biennium that includes the six-month period). If the fund balance exceeds six months of budgeted operating expenses, the Department of Consumer and Business Services will return excess funds to carriers on a pro-rata basis, computed from the December assessments, in the form of a credit applied against future assessments. The credit will be applied no later than the end of the first quarter of the calendar year.*]

(A) Example 1: If the Marketplace's fund balance is $1 million as of June 30, 2017 and its operating budget is $4 million for July 1, 2017 through June 30, 2019, the department would retain $1 million and credit carriers $0.00 because there is no excess fund balance - $1 million minus ($4 million divided by 4) is zero;

(B) Example 2: If the Marketplace's fund balance is $1 million as of June 30, 2017 and its operating budget is $2.4 million for July 1, 2017 through June, 2019, the department would retain an excess fund balance of $600,000 and credit a total of $400,000 to carriers - $1 million minus ($2.4 million divided by 4) equals $400,000; and

(c) Credit each individual carrier participating in the Marketplace an amount equal to the pro-rata share of any positive difference obtained from the calculation described in paragraph (9)(b) of this rule based on the total assessments the carrier paid to the department during the two-year period described in paragraph (9)(a)(A) of this rule plus the pro-rata share of the total assessments paid during the two-year period described in paragraph (9)(a)(A) of this rule by carriers no longer selling qualified health plans through the Marketplace.

(A) Example 1: If the difference in the calculation described in paragraph (9)(b) of this rule is less than or equal to zero on June 30, 2017, there is no excess fund balance and the department would not credit any individual carrier because the fund balance is either zero or negative.

(B) Example 2: If, after performing the calculation described in paragraph (9)(b) of this rule, the excess fund balance is $1.2 million on June 30, 2017, and Carrier A paid 10% of the total assessments the Marketplace received between July 1, 2015 and June 30, 2017, the department must credit Carrier A a total of $120,000 – $1.2 million multiplied by .10 equals $120,000.

(10) Except as provided in paragraph 11 of this rule, the department shall apply the credit described in paragraph (9)(c) of this rule by reducing each monthly charge assessed during the period described in paragraph (9)(a)(B) by one-twenty-fourth of the credit. For example, if, after performing the calculation described in paragraph (9)(b) of this rule, the excess fund balance is $1.2 million on June 30, 2017, and Carrier A paid 10% of the total assessments received by the Marketplace between July 1, 2015 and June 30, 2017, the department must credit Carrier A $5,000 per month in each month the carrier participates in the Marketplace between July 2017 through June 2019 – ($1.2 million multiplied by .10) divided by 24 equals $5,000.

(11) If the director determines that application of the credit as described in paragraph (10) of this rule would jeopardize a Marketplace carrier's financial solvency, the department may use any reasonable method to credit the carrier the amount due under paragraph (9)(c) of this rule.

Stat. Auth.: ORS 741.002 **and 741.005**
Stats. Implemented: ORS 741.105
Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15; Administrative correction, 9-30-15; OHIE 3-2015, f. & cert. ef. 10-15-15; OHIE 4-2015, f. & cert. ef. 11-6-15

House Bill 4017

Basic Health Program and 1332 State Innovation Waiver

Bill Summary (House Bill 4017)

1. Requires DCBS, in collaboration with OHA and a stakeholder advisory group, to report recommendations to interim committees of Legislative Assembly related to health for blueprint for Basic Health Program (BHP).

2. Grants sole authority to DCBS to submit a waiver for state innovation under Section 1332 of the Affordable Care Act.

Basic Health Program

Basic Health Program Summary
Section 1331 of the ACA gives states the option to establish a Basic Health Program to replace Qualified Health Plan (QHP) coverage through the Marketplace for people in households below 200 percent of the federal poverty level (FPL). BHP may provide increased subsidies or particular benefit packages for all people otherwise eligible for QHPs. The BHP may not cover any people who would be excluded from QHP coverage such as unauthorized immigrants, people eligible for Medicaid, children's health insurance program, or other minimum essential coverage.

BHP, like QHPs, can cover people with incomes 138 percent to 200 percent of the FPL and lawfully present non-citizens with incomes 0 percent to 138 percent of the FPL who are ineligible for Medicaid due to immigration status. The federal government will provide states approximately 95 percent of what would have been spent on advanced payment tax credits (APTC) and cost-sharing reductions (CSR) had those people been enrolled in QHPs through the Marketplace. No BHP funding may be spent on administrative costs.

The health plans must include essential health benefits. In states that implement a BHP, BHP-eligible individuals must enroll in the BHP and cannot receive federal subsidies to purchase QHPs on the Marketplace. Monthly premiums and cost-sharing for a BHP cannot exceed the amount the individual would have paid for coverage in the Marketplace. It is generally expected that BHP premiums and individual cost-sharing would be less than in a QHP. There is no federal funding to compensate for reduced premiums and cost-sharing paid by individuals; that funding needs to come from legislative appropriations.

In 2014, HB 4109 directed OHA to commission a study (the Wakely/Urban Institute report) of the costs and effects of operating a BHP in Oregon. That analysis determined that depending on benefit, provider reimbursement, and other choices, none of the four options modeled "broke

even," with annual deficits ranging from $1.6 million to $119 million. Because this study was done in advance of the launch of QHPs, the report included a range of assumptions about enrollment in both QHPs and a BHP. These numbers need to be updated to reflect current data. OHA presented the report to the 2015 Legislature without a recommendation to implement an Oregon BHP. The 2015 Legislature passed House Bill 2934, which directed OHA to convene a stakeholder group to examine key policy issues related to the possible implementation of the BHP in Oregon. This group submitted its recommendations to the Legislature in November 2015. In 2016, the Legislature tasked DCBS, in collaboration with OHA and in consultation with a stakeholder advisory group, to consider and address the recommendations produced in OHA's 2015 report.

BHP-Related Provisions in HB 4017

1. Create and present a report to the Legislature by Dec. 31, 2016, that:
    a. Considers and addresses the following recommendations:
        i. BHP participants should use the exchange's Internet portal to enroll in health coverage.
        ii. BHP participants should have a choice of enrolling in a standard health plan by a coordinated care organization or a commercial insurer.
        iii. BHP participants should not be subject to deductibles, co-insurance, copayments or other cost-sharing requirements.
        iv. BHP participants whose incomes are below 138 percent of the federal poverty guidelines should not be required to pay premiums and those who are above 138 percent should have their premiums determined on a sliding scale (ensure the premium is not grater than premiums those individuals would pay for a QHP less APTC).
        v. Allow individuals to remain continuously enrolled for 12 months so long as individual resides in Oregon.
        vi. Medical services should be reimbursed at a rate equal to the average rate paid by Medicare and commercial insurers.
        vii. Maintain the cost of the program at a fixed rate of growth annually.
    b. Includes a blueprint for a Basic Health Program.
    c. Describes the administrative framework for grievance procedures, premium billing, and providing customer service to BHP participants.
2. The BHP must serve, at a minimum, Oregon residents who are:
    a. Younger than 65 years old
    b. Ineligible to enroll in employer-sponsored health insurance that is affordable
    c. US citizens with incomes at or above 138 percent but no greater than 200 percent of the federal poverty guidelines or lawfully present noncitizens with incomes below 200 percent of the federal poverty guidelines who would qualify for the state medical assistance program but for their immigration status

BHP Resources and Considerations

- Wakely/Urban Institute legislative report regarding BHP, November 2014.

- OHA's legislative report regarding BHP, November 2015.
- Minnesota and New York have implemented BHPs and are looking at possible alternatives to their BHPs. Their experience, considerations, and decisions will be available. A number of other states did a BHP analysis, but declined to establish a BHP. Their considerations and reports will also be available.
- *Wakely/Urban Institute report update in 2016 expected by mid-April to May 2016.*
- Federal BHP resources and possible RWJF-funded consultation.
- As of October 2015, the federal platform cannot operationalize the state-specific rules needed to conduct BHP eligibility determinations for states such as Oregon, which rely on the federal technology for eligibility and enrollment determinations. CMS has advised Oregon they do not anticipate this will change. This will be included as part of the administrative cost and program integration considerations.

BHP Stakeholder Advisory Group Requirements and Considerations

- HB 4017 mandated participants
    - Advocates for low-income individuals and families
    - Advocates for consumers of health care
    - Representatives of health care provider groups
    - Representatives of coordinated care organizations; and
    - Representatives of the health insurance industry

- Possible Structure of BHP Stakeholder Advisory Group
    - Subgroup of OHIM Advisory Committee
    - Subgroup reports BHP recommendation to the full OHIM Advisory Committee

- BHP Stakeholder group representatives, including:
    - OHIM Advisory Committee members (2-3)
    - Immigrant communities
    - Oregon Center for Public Policy
    - Oregon Primary Care Association
    - Oregon Association of Hospitals and Health Systems
    - Oregon Medical Association
    - Coordinated care organizations
    - Health insurance industry

1332 State Innovation Waiver

State Innovation 1332 Waiver Summary

Under a 1332 Waiver, states can modify the ACA regarding covered benefits, subsidies, insurance marketplaces, and individual and employer mandates. States may propose broad alternatives or targeted fixes. All waivers must satisfy four criteria known as the "waiver guardrails":

- **Comprehensive coverage:** State must provide coverage that is "at least as comprehensive" as coverage absent the waiver.
- **Affordable coverage:** States must provide "coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable" as coverage absent the waiver.
- **Scope of coverage:** States must provide coverage to "at least a comparable number of residents" as would have been covered without the waiver.
- **Federal deficit:** The waiver must not increase the federal deficit.

State Innovation Waiver Related Provisions in HB 4017

- DCBS has sole authority to apply for a waiver for state innovation.
- DCBS will convene an advisory group to advise and assist.
- DCBS and the advisory group must consider alternative approaches for achieving the objectives of the BHP described above.
- Prior to any waiver submission, DCBS must present the proposed application to the Legislature.
- No later than March 1, 2017, DCBS will report to the Legislature any recommendations for a waiver.

State Innovation Waiver Ideas and Potential Approach

- Potential waiver ideas:
    - SHOP technology waiver (maintain status quo)
    - Resolve the "family glitch" by changing the "affordability" definition
    - Alternative approaches for achieving the objectives of the BHP
    - Explore any waivers that are necessary for a merged individual and small group market
- Approach:
    - Establish 1332 subgroups of OHIM Advisory Committee
    - Study short-term goals v. long-term planning and submit separate waivers

HB 4017 Timeline

HB 4017 Implementation and Development Timeline				
Date	**OHIM**	**OHIM Advisory Committee**	**BHP Subgroup**	**1332 Subgroup(s)**
March	Procurement for Wakely report update			
April	Receive Wakely update (report completion expected late-April – May)	**4/7 meeting:** OHIM presents: Fundamentals of BHP; BHP subcommittee recruitment Fundamentals of 1332; 1332 subgroup recruitment		
May			One-on-one meetings with OHIM/OHA staff and committee members Kick-off meeting late May Present: • Fundamentals of BHP • Review key findings from previous BHP studies and stakeholder engagement, experiences of other states, updated Oregon population and QHP enrollment analyses, etc. • Wakely update	Kick-off meeting late May Present: • Fundamentals of 1332 • Two-tiered approach (short term v. long term) • SHOP technology waiver
June	Staff work following BHP		Second meeting Present draft	Second meeting

	kick-off meeting		legislative BHP report	
July	Staff work to complete draft BHP report incorporating BHP subcommitte findings, Wakely analysis, experiences of other states, QHP enrollment data, consultant and CMS feedback, etc.		Third meeting Present final BHP report	Third meeting
Aug.				Fourth meeting
Sept.	Complete BHP report			
Oct.	Staff work to draft waiver recommendation			Fifth meeting Present draft waiver recommendation
Nov.			Present to legislature BHP report 12/31/16 statutory deadline to submit BHP report	Finalize waiver recommendation
Dec.				
Mar. 2017				Deadline to report to legislature any recommendations for a 1332 waiver