Department of Consumer and Business Services
Oregon Health Insurance Marketplace
Advisory Committee Meeting

June 11, 2020
11:00 a.m. – 1:00 p.m.
Phone: 866-377-3315
Access code: 1947713

Link to join: https://ohim.adobeconnect.com/mac-06-11-2020/
(you can choose to have the meeting call you)

Please note that this public meeting will be recorded.

A G E N D A

Time	Topic	Presentation Type	Presenter(s)
11:00 – 11:10 a.m.	Welcome and approval of meeting minutes		Dan Field Committee Chair
11:10 – 11:25 a.m.	Federal health policy movement	Updates	Stephanie Kennan McGuireWoods Consulting
11:25 – 11:45 a.m.	Oregon State Option report	Updates and discussion	Jeremy Vandehey Director of Health Policy and Analytics, OHA Stephanie Jarem Director of Office of Health Policy, Health Policy and Analytics Division, OHA
11:45 a.m. – 12:00 p.m.	Third party payment programs and hospital financial assistance	Overview	Sean McAnulty Enrollment Program Coordinator Mosaic Medical
12:00 – 12:05 p.m.	Break		
12:05 – 12:15 p.m.	2020 Open Enrollment data and 2021 target counties	Updates and discussion	Cable Hogue Marketplace Implementation Analyst and Federal Liaison

12:15 – 12:25 p.m.	2021 Marketplace carrier landscape and preliminary rates	Updates	Katie Button Marketplace Plan Management Analyst
12:25 – 12:35 p.m.	Other states' SBM transitions	Updates	Victor Garcia Marketplace Operations Development Specialist
12:35 – 12:50 p.m.	Draft Marketplace move to OHA legislative concept	Overview	Chiqui Flowers Marketplace Administrator Jeremy Vandehey Director of Health Policy and Analytics, OHA
12:50 – 12:55 p.m.	Public comment		Dan Field Committee Chair
12:55 – 1:00 p.m.	Closing remarks		Dan Field Committee Chair
Adjourn			

Department of Consumer and Business Services
Oregon Health Insurance Marketplace
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Meeting Minutes
Thursday, January 23, 2020 - 11 a.m. to 3 p.m.
Labor and Industries Building, Room 260
350 Winter St. NE, Salem, 97301

Committee members present: Kraig Anderson, Stephanie Castano, Dan Field (Chair), Joe Enlet, Jim Houser, Ken Provencher, Lou Savage (ex-officio), Shanon Saldivar (Vice-chair), and Jeremy Vandehey (ex-officio)

Committee members via phone: Jenn Welander

Members excused: Shonna Butler, Cindy Condon, Numi Griffith, Sean McAnulty, and Sandy Sampson

Other presenters: Stephanie Kennan (by phone), Rep. Alissa Keny-Guyer (by phone), Rep. Andrea Salinas, and Jackie Yerby

Marketplace staff: Chiqui Flowers, Administrator; Katie Button, Plan Management Analyst; Victor Garcia, Operations Development Specialist; Cable Hogue, Implementation Analyst and Federal Liaison; and Dawn Shaw, Division Support Coordinator

Agenda item and time stamp*	Discussion
Welcome and introductions, committee housekeeping 0:0:00*	Congratulated Jim Houser on his retirement, he has applied for reappointment for the committee. The committee agreed to postpone approving the meeting minutes from November 21 until later in the meeting until there were enough members present for a quorum. *Note: Minutes were approved at 2:05:20.*
2020 open enrollment data analysis, Part 1 0:02:22	Cable Hogue presented an update of open enrollment data received from CMS. *See the handouts posted on our website for presentation.* • Data presented is what CMS has allowed to be externally shared. Will present data percentage differences from last year. In March, CMS will release the full data set and we will be able to share details that are more specific at that time. • Overall plan selections is 145,264 and down 2% from last year (148,180). Factors that could have contributed is a lower unemployment rate. • In February, we will have data on how many effectuated (paid a premium on their plan) data to have a better idea on the actual enrollees. Typically, there is an 85-92% effectuation rate. • Auto re-enrollments, passive enrollments is up 10% from last year. Usually due to people being happy with their plans. They could have researched options and decided they wanted to continue with their plans. • New consumers are down 8%. These are individuals who have selected a QHP, have non-canceled 2020 coverage and did not have 2019 coverage as of 12/31/2019. • Active plan selection down 3% from last year.

- APTC plan selections down 2.7%.Could be caused by the changes in the calculation and in a few counties, changes in the second lowest silver plans. Since we do not have better access to the data, we can only speculate.
- CSR (cost sharing reduction) plan selections down 3.1%. Possible reasons are that people with low medical needs moved to bronze plans (3.6% increase) to save on premiums or or those with high medical needs going to a gold plan (2.3% increase). There was a 5.9% decrease in silver plan selections.

Rep. Andrea Salinas arrived, the question and answer section of this presentation is continued below.

Health care priorities and future plans, part 1

0:08:15

Rep. Andrea Salinas from District 38 of the Oregon Legislature discussed her health policy priorities and legislative priorities.

- Is the chair of the House Health Care Committee and has served in that capacity for not quite a year, on the Behavioral Health Committee, Human Services sub-committee, and serves on the Public Employee Benefit Board (PEBB).
- Attended the Oregon Health Forum, discussed bigger picture items. We are asking everyone to pitch in and help to control health care costs. SB 889 is helping with the cost containment discussions. Enforcing benchmarks will help.
- In the next long session, there will be some bigger discussions.
- Hospital Charity Care and Community Benefit Board is going on, they are looking at hospital spending.
- There are some prescription drug bills that pharmaceutical companies are challenging.
- The next big thing on the horizon is how to integrate behavioral health care with primary care. Making sure that everyone has access, in spite of not having a meaningful workforce statewide and that we are spending money in the right places.
- Looking into containing the cost of dialysis.
- SB 770 has a task force looking into Oregon getting universal access to care. Main goal is to make sure patient care is uniform, there are similar metrics, and there is value based payments. Jeremy (OHA) is working on the RFP on a public option that makes sense for uninsured and under insured. Feedback is appreciated and was discussed.
- Is behind Oregon having their own platform.

Division of Financial Regulation (DFR) Panel, part 1

0:30:25

Andrew Stolfi, Insurance Commissioner and DFR Administrator; Tashia Sizemore, DFR Insurance Product Regulation and Compliance – Life and Health Section Manager; and Jesse O'Brien, DFR Senior Policy Advisor, discussed the Oregon Reinsurance Program, planned changes for the 2021 rate filing process, and 2020 legislative session bills.

- Reinsurance Program
  - Benefits include a 6% reduction in premiums.
  - 2020 is the third year it has been in effect, we were one of the first states and there are now more than ten states. Every state that has come after us has asked us for consultation.
  - There is a time lag between making a commitment to the carriers to fund the Reinsurance Program and when the payments are ultimately made. For example, in 2018, there had to be a commitment for a $90 million dollars in state and federal funds in 2017. Affected rates in 2018. In 2019, carriers had until June 1 to close the books on the 2018 PY and to give us all the data.

Auditors went on site to the carriers around October/November 2018, disbursements issued by December 2019.
    - We have to estimate how much money we will be getting from the federal government. We just received a $54.4 million award for PY 2020. 2019 went down to $41.8 million. The more money we get from the feds, the less state dollars we have to put in.
    - Two bills passed to fund the program. In a few years, there will need to be a discussion on what to do with the program.
    - There may be a change in the geographic rating areas.
    - Questions about a high-risk pool. As a state, we did look into it but due to the way that the ACA is structured, it has prevented the creation.
    - Do not anticipate changes within the next few years but can be impacted by SB 770.
- Program integrity rule requires separate invoicing for abortions. DFR is doing outreach to the carriers. Will see if this goes into affect. There is a non-enforcement option. Carriers can choose not to terminate someone if they fail to pay the separate $1 bill.
- For the standard plans for 2021, there will be an advisory committee meeting next week to go over the options.
- Colorado passed a law and Washington is looking into a law to cap monthly out-of-pocket payments. We are exploring if we have the authority to go forward with something similar.
- Looking at updating the EHBs and the benchmark plans.
- Rick Blackwell has left DFR.
- Any complaints about drug pricing and coupons should go to DFR.
- Planning on having the due dates for rate filings to be similar to last year. Dates subject to change depending on when CMS finalizes their dates. With the forms, looking at moving the filing date back to June to marry it closer to the plan and benefits filing so it isn't as confusing.
- Tashia is looking at creating a standardized review for questions for the form side. There are currently review questions on the rate side. This will be more proactive than the data calls so things are ironed out before reaching consumers.
- SB 526 for in home visits, we are coordinating with OHA.
- For Insulin caps, we are looking at what the actuarial lift would be.
- Next Friday, DFR will be holding an LTC insurance forum. It will be live streamed as well.
- DFR Legislation
    - HB 4110 is the one bill that DFR is proactively working on. This came out of the work group on alternatives to short-term health plans. Bill is designed to prevent people from falling through the cracks by accidentally missing a premium payment and confusing notifications. Extends non-ACA plans' grace period to 30 days from the current 10. Will set up a 15-day grace period for the effectuation payment. Currently, there is no guidance and it is up to the carrier. Looking at getting better notifications and the ability to write rules.

Rep. Alissa Keny-Guyer called in, this topic will be continued at 1:34:30.

Health care priorities and future plans part 2	Rep. Alissa Keny-Guyer from District 46 of the Oregon Legislature discussed her health policy priorities.

1:15:13

- Dan informed us that Rep. Keny-Guyer will not be seeking reelection and this is an opportunity for us to thank her for her service.
- Is on the Health Care Committee and has a degree in Public Health. Her passion is prevention and social determined mental health.
- Bills that she is focused on comes out of her Human Services and Housing Committee.
- Her priorities are trying to break the cycle of issues like homelessness and child welfare as a result of not getting on top of mental health and addiction. We have one of the highest rates of addiction and the lowest rates for mental health and addiction services.
- HB 4040 – Family Treatment Court Bill will provide evidence-based wraparound and parenting support for parents receiving addiction treatment.
- HB 4112 – Omnibus Child Abuse Prevention/Treatment, focus is on how to get insurers to reimburse medical directors more evenly throughout the state.
- There are two bills around kids aging out of foster care at 18. Doing a better job in preparing them for adulthood.
    - HB 4120 – Independent Living Program, requesting an increase for case management. The rate has been $200 and has been the same for years.
    - HB 4039 – Unaccompanied Homeless Youth provides grants for providers who provide shelter and other services and will fund host home programs.
- The top four bills did not pass. If something is not done, we will have an increasing continuing service level.
- Understands the need to transition to a state-based marketplace.

DFR Panel, part 2

1:34:30

Jesse O'Brien wrapped up his presentation on DFR legislative bills.

- LC 6 – Dialysis concept, would cap the reimbursement for dialysis services at the Medicare rate for all commercial plans. Would also cap the patient out-of-pocket at 10%. The intent is for there not to be balance billing.
- LC 7 – would create a DCBS committee to review health insurance mandates, specifically the ACA provision where the state has to defray the cost of benefit mandates in excess of EHB. We don't think it will go forward in its current form.
- LC 18 – Rep. Mitch Greenlick's latest run to refer a question to the ballot that would establish access to care as a right in the Oregon constitution.
- LC 59 – concept from the Oregon Medical Association to reform prior authorization (PA), step therapy, and utilization management. Would extend the time period the PA is good for. Would carve out OEBB and PEBB, not CCOs.
- LC 92 – big healthcare omnibus bill. Extends the timeline for the Universal Access to Care task force. Looks at CCO financial transparency and number transfers. Provision at the end about auto repeal of old health insurance mandates.
- LC 102 – pre-exposure prophylaxis, prevent the transmission of the HIV virus. The US preventative services task force recently recommended that the medication be added to the list of services that are available without cost share. Will go into effect soon. This bill would ban PA for those therapies, will add to the list of medications that pharmacists can prescribe. Would require reimbursement to the pharmacist, even if the pharmacy is out-of-network. Would apply to other medications prescribed by pharmacists.
- LC 134 – drug price transparency, extends the task force.
- LC connected to capping insulin, cap copayments to $100. Will create a system for drug transportation from Canada.

Federal health policy movement

1:45:55

Stephanie Kennan from McGuire Woods Consulting called in from Washington D.C. to present information about current legislation and cases that involve the ACA.

- December 22, 2019, the government was funded for the fiscal year. In the bill, there was a repeal of the Medical Device Tax, Health Insurers Tax, and the Cadillac Tax. Cost $375 billion before interest over ten years.
- Surprise billing is still an issue. At the end of last year, there was a bipartisan agreement on how to move forward. Earlier this month, the Ways and Means leadership drafted their own bill. House would like to get it done by May.
- Drug pricing - House passed what is known as the Pelosi bill. Some bills are awaiting the result of the finance package.
- Several states are looking at ways to export medicines from Canada.
- Abortion and payment - the bills for abortion services need to be sent as a separate bill. Effective June 2020. The rule also steps up oversight of state based exchanges and APTC and requires periodic data matching.
- Texas v Azar is back to the lower courts to go through it with a fine toothed comb. More to come.
- Other court cases include risk corridor, cost sharing reduction payments, short-term plans, contraception mandate, ACA non-discrimination provision, and a case about the president not doing his due diligence in enforcing the law. Rulings on these cases should happen some time this year.
- Medicare put in a policy about site neutral, which means that when you get a surgery it doesn't matter the location (OP clinic, doctor's office, hospital, etc.) you will pay the same price. Went into effect, but the court case is ongoing. There is also the transparency case requiring hospitals to make prices known.
- Public charge rule had some action recently. This week, the administration asked the Supreme Court for an emergency ruling to lift the nationwide injunction issued by NY judge. There isn't a ruling yet.
- Ruling in May by HHS Office of Civil Rights addressing medical professionals refusing to see patients due to religious affiliations or moral objections. There are multiple lawsuits on this as well.
- There may be a future bill about giving patience more access to their medical records.

MAC business

2:05:20

Approved the November 23 minutes.

Farewell to Cindy Condon, who was unable to attend, and Stephanie Castano. Both received a certificate recognizing their service.

State-based marketplace transition analysis

2:10:40

Victor Garcia provided an update on the state-based market place transition from the current federally facilitated model we currently have.
See the handouts and update for slide 4 posted on our website for presentation.

- Updates on other states transitioning to a fully state-based marketplace (SBM)
    - Nevada – had their first OE 2020 was successful. They had a similar experience to ours with a failed first SBM in plan year 2014.
    - New Mexico – selected vendor in 2019. Launch target for OE 2022.
    - Pennsylvania – RFP requested a vendors provide a single submission for both technology and consumer assistance center (CAC) for customer support. A vendor has been selected with a November 2020 launch target for OE 2021.
    - New Jersey – changing from federally facilitated marketplace (FFM) to SBM, and announced vendor selections at the start of 2020. The state

chose separate vendors for technology and consumer support. Anticipated launch is in fall 2020 to be ready for OE 2021.
    - Virginia – bills have been introduced in the 2020 session, waiting to hear the session outcomes.
    - Maine – transitioning from FFM to SBM-FP in 2020 for OE 2021, bill introduced in 2020 session. No specific plans announced for transition to a full SBE yet.
- Went over the comparisons for the OE enrollees from 2019 to 2020. Nevada is the only one that had the full transition. Some numbers can be attributed to Medicaid expansion.
- Showed a cost comparison of technology and CAC for Nevada, New Jersey, Pennsylvania, and Oregon for the first year of maintenance and operations, projected first year average enrollment, and the annual per member per month costs. Oregon's numbers are based on our current use of the federal platform and shows costs almost three times higher than the other states' projections.
- We are working on a high level business case right now. Budget estimates are based on other states contracts and implementations. Projecting multiple assessments in advance. Our homework is reaching out to the other states on their experiences, external resources available through partners, and looking at other states' RFP requirements.
- Ongoing Marketplace work includes business process mapping, setting the annual assessment, and 2021 session prep, all of which will contribute to the business case for an SBM transtion.
- The committee asked about the funding for an SBM transition: are we going to have the funds up front? Answer: There may be enough in reserves for initial design, development, and implementation of a technology and CAC, but it depends on timing and would need to be evaluated closer to an RFP. Pensylvania was able to defer and divide all initial DD&I costs over the life of the contract starting in the first plan year, and vendors seem amenable to that arrangement. It depends on what the vendors will agree to. We don't anticipate asking for general funds.
- Discussion on going forward may be delayed pending discussions and decisions on if the Marketplace stays with DCBS or moves to Oregon Health Authority. The structure of the platform wouldn't change regardless, but the timing of a transition project and resource allocation would be impacted. OHA has a larger infrastructure for handling IT projects. Still looking at where the Marketplace would fit best and be best positioned going forward. We will still be doing the prep work that can be done now.

Window shopping tool

2:53:53

Katie Button presented and update for the window shopping tool and discussed future considerations.

- The shopping tool was released on October 18, 2019.
- From October 18 to December 17, 2019, accounting for the extension of OE due to technical issues with HealthCare.gov. There were a total of 35,337 unique users that used the shopping tool. Our goal was 20,000.
- Majority of users were in Portland, followed by Eugene and Bend. Had some users in random places like San Francisco.
- Average time consumers stayed on the site was seven minutes. Many entered their household information and browsed plans.
- Implementation and maintenance is very easy, with no major issues. Feedback has been positive. Consumer checkbook was great at troubleshooting issues and working with us.

- We are looking at possible upgrades for 2021 including provider and formulary searches. We will be looking at getting input from stakeholders on potential upgrades they would like to see

Marketplace Assessment Refund Rule
 	
2:59:13
	Anthony Behrens went over the hearing for amendments to OAR 945-001-0002 and OAR 945-030-0020 about the Marketplace Assessment Refund Rule.
	• Rulemaking to finalize temporary rules issued September 2019. Needed to improve the rebating procedure and could not do so via regular rulemaking.
	  ○ Adding a definition for biennium, match the states budgetary period.
	  ○ Reduced rebate crediting period from 24 to 12 months
	  ○ Specification of rebates being credited beginning January of the following biennium.
	  ○ Rebate credits to be paid in 12 monthly installments, first 11 to be equal dollar amounts with the 12th month being what ever is left.
	  ○ Clarified that a carrier is: entitled to pro rata share of rebates owed to carriers no longer participating in the Marketplace, not entitled to the rebate if they didn't pay assessments or are a participant in the Marketplace.
	• Should not be any impact to the public.

2020 open enrollment data, Part 2 3:07:20	Cable Hogue continued the updates of the 2020 open enrollment data. • There was not a significant change in premiums after APTC. APTC did increase by $9. • People on subsidies did change 2.7% lower than it was previous. CMS indexing changed. • Trends are that a higher people are effectuating. Consumers seem to be making a more informed choice about the tier that they are in. Elizabeth worked with the media to highlight what they could be eligible for. • SEPs have increased plan selections. • Auto enrollments are going up every year. Consumers may have actively shopped but decide to stay with the plan that they are in. • More detailed data could be better in determining why or why not people change plans.
Closing	Reappointment confirmations will be February 5. Next meeting will be Thursday, April 16, 2020.

*These minutes include timestamps from the meeting audio in an hours: minutes: seconds format. The meeting audio can be found on the advisory committee web page (link below) under 2020 Meetings, January 23.

Meeting materials are found on the Oregon Health Insurance Marketplace Advisory Committee website: healthcare.oregon.gov/marketplace/gov/Pages/him-committee.aspx

Senate Bill 770 (2019): Developing a Plan for a Public Option or Medicaid Buy-in

Presentation to the Marketplace Advisory Committee
June 11, 2020

Oregon Health Authority

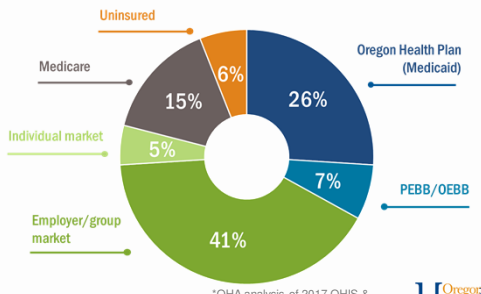
What is Public Option?

Public option, also known as public health insurance, refers to a government-run health insurance plan that would compete with existing private health insurance plans, with the goal of making insurance more affordable. There are many ways a public option plan could be implemented.

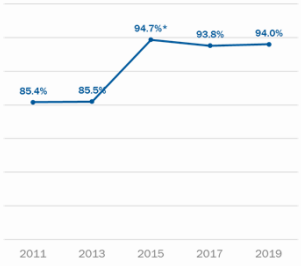
What is Medicaid Buy-In?

Medicaid buy-in is one type of public option, which would allow people not otherwise eligible for Medicaid "buy-in" to health coverage through Medicaid. Under this type of plan, people would pay a monthly premium to enroll in Medicaid, but federal Medicaid funds would not be available.

The State of Oregon is the largest health care purchaser. OHA purchases health care for 1.3 million Oregonians.



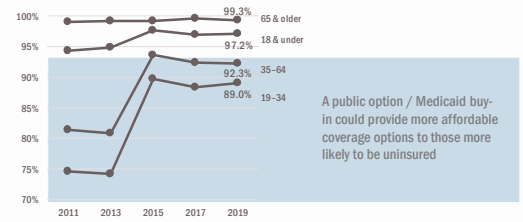
*OHA analysis of 2017 OHIS & PEBB/OEBB enrollment data



After Affordable Care Act driven growth in 2014-2015, the percent of Oregonians with insurance coverage has stalled

* statistically significant difference from the previous year at 90% confidence level.
Source: point in time health insurance, Oregon Health Insurance Survey, 2011-2019

And adults who are under age 65 are more likely to be uninsured



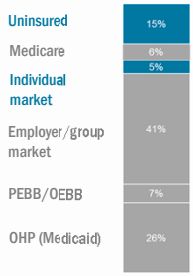
A public option / Medicaid buy-in could provide more affordable coverage options to those more likely to be uninsured

Source: point in time health insurance by age, Oregon Health Insurance Survey, 2011-2019

Senate Bill 770

What does it do?

SB 770 includes a Broad *and* Narrow focus



Public Option / Medicaid Buy-in focused on the 11% in Individual Market or Uninsured

Task Force on Universal Care focuses on Oregon's entire health insurance market

Public Option / Medicaid Buy-In

SB 770 directs OHA to develop a plan to "provide an affordable health care option to all Oregon residents" with a focus on those "who do not have access to health care."

Considerations:

- No net cost to the state
- Comprehensive benefits
- Minimal cost sharing
- Use CCO model
- Account for distribution of risk
- Use premium tax credits
- Maximize federal funds
- Use CCO provider networks

Public Option / Medicaid Buy-In

The plan must also include:

- Potential eligibility requirements
- Legislative changes needed to implement
- Federal approval needed to implement
- Options for specific populations
  - Residents with income 4-6x federal poverty level who cannot afford insurance
  - Residents who cycle through Medicaid and employer coverage
  - Other groups that face significant barriers to accessing health care

Task Force on Universal Health Care

SB 770 establishes this taskforce to recommend the design of the Health Care for All Oregon plan, a universal health care system that is equitable, affordable and comprehensive, and available to every individual in Oregon.

Current status of SB 770 work

Public Option / Medicaid

OHA is developing proposals to provide an affordable coverage option for more Oregonians. OHA plans two reports in 2020.

Task Force on Universal Health Care

The Task Force is currently suspended due to the COVID-19 emergency.

Senate Bill 770

Public Option / Medicaid Buy-In Report Progress

Development Process

OHA and DCBS staff identified three models:

1. A product offered and delivered by existing Medicaid CCOs
2. A product offered and delivered by commercial insurance carriers
3. A state-backed product delivered by a Third-Party Administrator

Working with contractor (Manatt) to refine these models and implementation options

Development Plan

Pre-COVID

- Draft report shared publicly in June
- Stakeholder engagement
- Refine recommendations
- Final report to legislature Fall 2020

Now

- Initial report released July 2020
- No summer stakeholder engagement
- Second quantitative report Fall 2020
- Adding COVID19 context to reports

Initial Report Content

For each of the three models, the report will examine:

- Potential program design structure
- Feasibility and implementation challenges
- Performance relative to legislative goals
- Statutory and regulatory barriers
- Options to navigate barriers
- High level discussion of COVID-19 impact

Quantitative Report Content

The Fall 2020 report will include a more detailed analysis:

- State-specific data on reimbursement rates
- Projected premiums, participation and impact on existing markets for each of the three models
- Consideration of any post-COVID data to provide context

Too early for recommendations

Key Challenges

- No model can solve all policy goals or meet the needs of all Oregonians
- Model design depends on which populations and policy goals are prioritized
- There are tradeoffs between affordability, participation, financing, and other challenges that need to be understood

COVID-19 introduces more uncertainty

Hospital Financial Assistance and Third Party Payment Programs

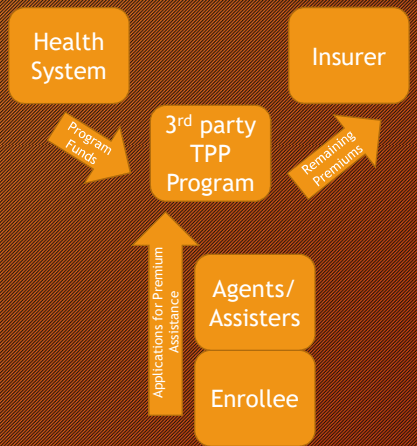
Hospital Financial Assistance Programs

- HB3076 requires nonprofit hospitals and affiliated clinics have financial assistance program
  - 2020: 100% writeoff of patient's bill if under 200% fpl
  - 2021: 75% writeoff from 200-300% fpl, 50% for 301-350% fpl, 25% for 351-400% fpl
  - Baseline; many areas have more generous limits
- Important safety net for un- and under-insured; deductibles less of a barrier to care
- Availability of other financial assistance makes enrollment less financially beneficial
  - 2017: single adult 150% fpl silver paid $60/mo in premiums (4.1% of income)
  - Then: $60 premium weighed against $57.50/mo tax penalty, so only $2.50 additional cost for a plan
  - Now: $60/mo premium weighed vs no-cost financial assistance, no tax penalty, reduced risk
- Still risky for patient to rely on FA alone; less access to medications, specialty services, outside referrals, contracted services like anesthesiology, easy to get out of FA network bill
- Choosing to go uninsured or take a bronze over silver plan leaves local health system bearing more costs as uncompensated care

Third Party Payment Programs

- Health Systems, local governments, tribes, etc are able to pay marketplace premiums on behalf of enrollees in their service area
  - Most programs pay 100% of remaining premium after tax credits
  - Patient is generally still responsible for out of pocket costs; some programs use reimbursement model or integration with FA programs to prevent most of these expenses
- Enrollment in marketplace plan leverages tax credits and 87-94% value silver plans to pay for care that would otherwise be eligible for 100% writeoff via financial assistance
- Reductions in uncompensated care outweighs premiums paid
  - A PANOW funder found a $400k reduction in uncompensated care for 44 studied program enrollees. Savings for these 44 enrollees alone is more than double their $200k contribution to program (which funds roughly 85 peoples' premiums)
  - Commonwealth fund study of 5 nonprofit TPP programs found all were beneficial to donor organization

Program Structure



- Structure (nongovernmental): Health System donates to third party organization that processes payments, which works with local assisters/agents to enroll people.
- Requirements against self-dealing: Donor must provide premium funds to third party organization for distribution. Can be a hospital-associated foundation.
- Requirements against adverse selection: Program must be open to anyone who meets program's eligibility criteria. Can require they go through agent/assister referring partner, but a health system cannot selectively refer only its sickest patients into premium assistance
- May restrict to particular metal levels, carriers, plans, etc, but after that cannot restrict choice between participating plans

Existing TPP Program Examples

- Washington Health Benefit Exchange:
  - 18 programs, 3293 sponsored enrollees, total $464000/mo in premiums paid
  - State facilitates and oversees local TPP programs ("sponsors"), transmits payment info from sponsor to carrier, registered programs appear in carriers' payment system; QHPs required to accept payments from a WAHBE certified TPP program
  - Project Access NW: <300% fpl, joint funded by some of the local health systems
  - Pierce County Project Access: <400% fpl, joint funded by both local health systems
  - Evergreen Health Insurance Program: <425% fpl, state funded via Ryan white care act+state AIDS omnibus
  - Tribal Sponsorship Programs: 12 tribes sponsor programs for their members
  - Washington State Health Care Authority: TPP structure+SBE allows COFA, HIPP programs integrated into Wahealthplanfinder
- Oregon:
  - COFA: State funded but follows same wraparound model
  - Project Access NOW: 650 enrollees, <300%fpl, joint funded by all 6 Portland Health Systems
- Wisconsin: United Way of Dane County
  - ~1150 enrollees <150%fpl, joint funded by some local health systems
  - Smoker Surcharge Experiment: 51% more likely to renew insurance if $0 premium vs $70 per month (41% discontinued)
- North Carolina:
  - United Way of the Greater Triangle; 100-175% fpl, joint funded by both local health systems

Impacted Population

- Size of population depends on income cutoff; cutoffs usually structured around CSR tiers with <200% fpl population both the most price sensitive and getting 94%/87% actuarial value plans
  - Focus groups mentioned in last meeting identified price as significant barrier for 138-200%
  - Funders have found it cost effective to raise income limits to 300% or higher; assuming 200% limit for this slide
- Commonwealth fund poll of PA enrollees: in absence of free plan 53% would be uninsured, 29% would buy more limited coverage, 16% didn't know, 2% said coverage would be unaffected
- Potentially eligible:
  - Urban institute (BHP study): 91000 potentially eligible <200% fpl
  - 2016 CMS enrollment stats: 52000 potentially eligible <200% currently enrolled in QHPs would save money
  - Wakely projections: free BHP with no cost sharing would reduce uninsured by 16,600 (out of remaining ~100,000; serves as an optimistic projection of possible impact at 200% fpl income limit)
- Specific Underserved Populations:
  - Urban Institute: 4000 tax credit eligible immigrants barred from Medicaid; in 2016 2500 <100fpl QHP enrollees
  - DCBS' BHP response: "reasonable to assume 6500 older Oregonians are ineligible for free part A"

Possible Implementation

- Model currently in use successfully in Washington, Oregon, elsewhere
- Voluntary network of programs across the state is uniquely low-barrier method of expanding access to coverage
  - Does not require state funding or legislation
  - Does not require change in technology platform
  - All marketplace carriers in the state already have experience working with COFA and/or PANOW programs
- Upcoming budget crunch limits state funding options; saves health systems money and brings more money into state economy via tax credits
- Challenge of how to get a bunch of entirely voluntary programs started
- Washington's marketplace takes an active role in creating program framework, granting legitimacy, convening carriers+funders+programs
- Could DCBS find a way to help a network of these programs spring up across the state given limitations on budget?

2020 Open Enrollment Data

Source: 2020 Public Use Files courtesy of CMS

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2020 Open Enrollment Data

- Overall Plan Selections: **145,264**. Down 2% from last year (148,180)
- Auto Re-enrollments: **30,306**. Up 10% from last year (27,512)
- New Consumers: **32,744**. Down 8% compared to last year (35,617) (New Consumers are: unique individuals who have selected a QHP with non-canceled 2020 coverage where the consumer does not have 2019 coverage on 12/31/2019 and where the 2020 plan selection is not an auto-enrollment.

2

2020 Open Enrollment Data

- Returning Consumers with an active plan selection: **82,214**. Down 3% from last year (85,051)
- **104,099** plan selections with APTC
- **45,223** plan selections with CSR (Cost Sharing Reductions)
- **62,350** Bronze Plan selections
- **18,332** Gold Plan selections
- **63,826** Silver Plan selections

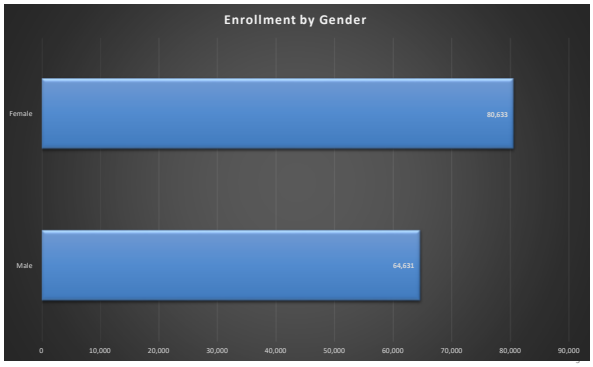
3

2020 Open Enrollment Data

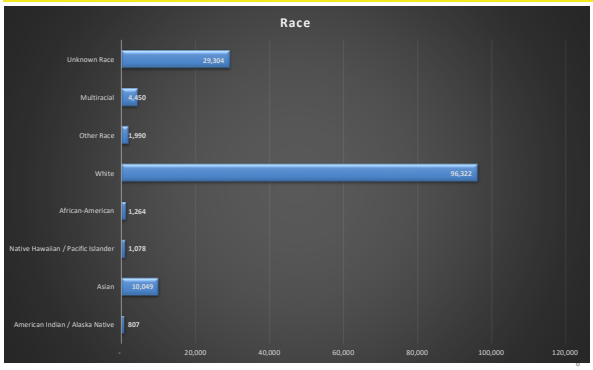
- Average premium for all marketplace plan selections: **$558** per month
- Average APTC for those receiving APTCs: **$456** per month
- Average premium after APTC for those receiving APTCs: **$137** per month

4

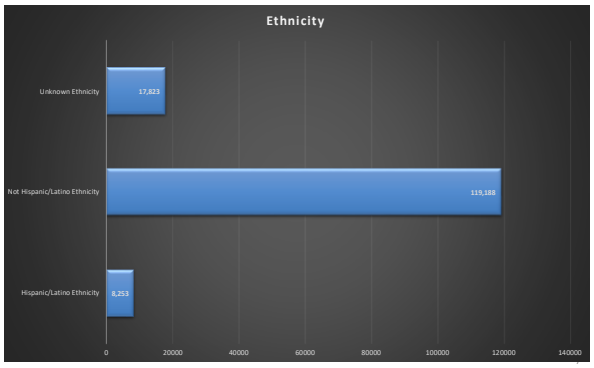
2020 Open Enrollment Data



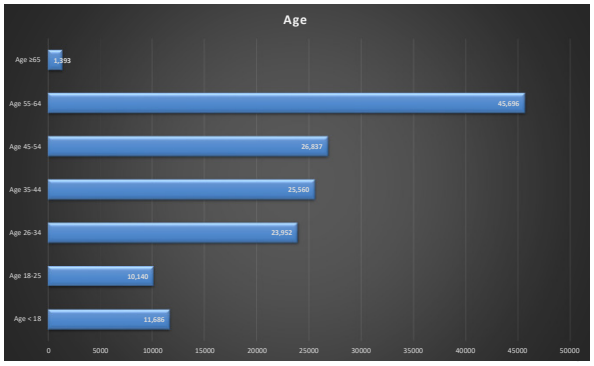
2020 Open Enrollment Data



2020 Open Enrollment Data



2020 Open Enrollment Data



Proposed 2021 Marketplace Plans and Rates

Katie Button
Plan Management Analyst

OREGON HEALTH INSURANCE MARKETPLACE

County Expansions

- Medical carriers are moving back into counties in 2021
  - BridgeSpan will offer plans statewide
  - PacificSource is moving back into Douglas, Josephine and Jackson Counties
- Regence has been approved to offer plans on-exchange and will be offering plans statewide
- Lincoln County will have three carriers; all other counties will have at least four
- All counties will have non-standard plan options for the first time since 2017

2

2021 Rates

2021 Medical Plan Rate Requests

Company	Average Rate Request	Requested Portland Silver 40-Year-Old Rate
Kaiser	-3.5%	$425
Moda	4.7%	$442
Providence	2.6%	$454
PacificSource	4.2%	$460
Regence	2.5%	$478
BridgeSpan	11.1%	$490

3

Rate Review Timeline

- Medical plan rates were filed May 18th
- The Division of Financial Regulation (DFR) is currently reviewing the filings
- Preliminary decisions will be announced in early July
- Rate hearings will be held after preliminary decisions are announced
- Final decisions will be announced in August

4

2021 Bronze Plans

- Actuarial Value (AV) Calculator changes will force increased cost-sharing in bronze plans
- Maximum Out of Pocket (MOOP) and deductible limits increased by $400 to $8,550
- Even with large increases to MOOP and deductible, cost-sharing must also increase to meet AV requirements

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2021 Oregon Health Insurance Marketplace Individual Plan Offerings

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Baker	23	Bridgespan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Benton	34	BridgeSpan	3	0
		Kaiser*	10	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1
Clackamas	66	BridgeSpan	6	0
		Kaiser	10	1
		Moda	10	1
		PacificSource	9	1
		Providence	7	1
		Regence	24	3
Clatsop	25	BridgeSpan	3	0
		Moda	10	1
		Providence	4	1
		Regence	8	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Columbia	35	BridgeSpan	3	0
		Kaiser	10	1
		Moda	10	1
		Providence	4	1
		Regence	8	1
Coos	25	BridgeSpan	3	0
		Moda	10	1
		Providence	4	1
		Regence	8	1
Crook	32	BridgeSpan	3	0
		Moda	8	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1
Curry	25	BridgeSpan	3	0
		Moda	10	1
		Providence	4	1
		Regence	8	1
Deschutes	24	BridgeSpan	3	0
		PacificSource	9	1
		Providence	4	1
		Regence	8	1
Douglas	32	BridgeSpan	3	0
		Moda	8	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Gilliam	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Grant	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Harney	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Hood River	38	BridgeSpan	3	0
		Kaiser*	10	1
		Moda	10	1
		Providence	7	1
		Regence	8	1
Jackson	34	BridgeSpan	3	0
		Moda	10	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1
Jefferson	32	BridgeSpan	3	0
		Moda	8	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Josephine	34	BridgeSpan	3	0
		Moda	10	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1
Klamath	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Lake	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Lane	42	BridgeSpan	3	0
		Kaiser*	10	1
		Moda	8	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1
Lincoln	15	BridgeSpan	3	0
		Providence	4	1
		Regence	8	1
Linn	34	BridgeSpan	3	0
		Kaiser*	10	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Malheur	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Marion	33	BridgeSpan	3	0
		Kaiser	10	1
		Moda	8	1
		Providence	4	1
		Regence	8	1
Morrow	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Multnomah	66	BridgeSpan	6	0
		Kaiser	10	1
		Moda	10	1
		PacificSource	9	1
		Providence	7	1
		Regence	24	3
Polk	33	BridgeSpan	3	0
		Kaiser	10	1
		Moda	8	1
		Providence	4	1
		Regence	8	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Sherman	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Tillamook	25	BridgeSpan	3	0
		Moda	10	1
		Providence	4	1
		Regence	8	1
Umatilla	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Union	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Wallowa	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Wasco	25	BridgeSpan	3	0
		Moda	10	1
		Providence	4	1
		Regence	8	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Washington	66	BridgeSpan	6	0
		Kaiser	10	1
		Moda	10	1
		PacificSource	9	1
		Providence	7	1
		Regence	24	3
Wheeler	23	BridgeSpan	3	0
		Moda	8	1
		Providence	4	1
		Regence	8	1
Yamhill	44	BridgeSpan	3	0
		Kaiser	10	1
		Moda	10	1
		PacificSource	9	1
		Providence	4	1
		Regence	8	1

* Kaiser does not cover all zip codes within this county.

Please note that this table has been compiled based on initial plan filings and may be subject to change. Plan offerings are not final until certification in September 2020.

Updates on States Transitioning to SBM

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OREGON HEALTH INSURANCE MARKETPLACE

Progress update: Other transitioning states

Nevada

- First OE as full SBM for 2020 was successful, no significant technical hurdles
- NV governor declared public health emergency March 12, 2020 due to COVID-19 pandemic
- Nevada Health Link was able to open an exceptional circumstance SEP for COVID-19 from March 17 to May 31
- OE 2019 enrollment as SBM-FP: 83,449
- OE 2020 enrollment as SBM: 77,410 (-7.2%)
- Additional COVID-19 SEP Enrollment: 5,479

Progress update: Other transitioning states

New Mexico	• Selected vendor in 2019 • Still SBM-FP for 2020 and 2021, November 2021 launch target for OE 2022
Pennsylvania	• Passed legislation in June 2019 to become SBM • Selected 7-year tech and CAC contract with vendor, announced in Dec. 2019 • Nov. 2020 launch target for OE 2021 • SBM-FP for 2020, planned move to SBM in 2021

Progress update: Other transitioning states

New Jersey	• Change from FFM to SBM-FP for 2020 • Announced vendor selections in January 2020 • Anticipated launch is fall of 2020 for OE 2021 • Separate contracts for tech (7 years) and CAC (3 years)
Virginia	• Bills passed in April 2020 for full SBM switch • Plans to have SBM in place for 2023, no other milestone dates currently available

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Progress update: Other transitioning states

Maine	• Passed legislation to begin SBM transition in March 2020 – LD 2007/HP 1425 • Set to become SBM-FP for CY 2021, with dedicated position funding starting in FY 2021 • RFI released March 30, 2020 and closed April 24

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Legislative Concept to Transfer the Oregon Health Insurance Marketplace from the Department of Consumer and Business Services to the Oregon Health Authority

For 2021 legislative session, Oregon Gov. Kate Brown has submitted a proposal to move the Oregon Health Insurance Marketplace from the Department of Consumer and Business Services (DCBS) to the Oregon Health Authority (OHA). The current version of the legislative concept (LC) contemplates that the Marketplace will move as a complete and distinct program. As such, the Marketplace would retain all of its current duties and responsibilities, including the following:

- Outreach and education, including the maintaining a Partner Agent program, a Community Partner program, and a Tribal Relations program
- Call center
- Plan management
- Carrier relations and contracting
- Compact of Free Association (COFA) Premium Assistance Program

The LC is based on, and is very similar to, Senate Bill 1 (2015). The following summarizes the relatively few differences:

- The Marketplace, including its call center, will transfer as a separate and distinct program with all of its employees.

- A dental carrier that offers Marketplace-certified coverage off exchange will be required to pay an assessment equal to the assessment Marketplace carriers pay to offer the same coverage. Currently, the Marketplace certifies off-exchange dental plans that meet standalone dental plan requirements; however, these plans are not required to pay assessments. This new provision will require that all dental carriers be treated equitably.

- Employer size for purposes of Small Business Health Options Program (SHOP) participation will be aligned with the definition of small group in the insurance code.

- The Marketplace will have specific authority to establish state special enrollment periods (SEPs) as long as they do not conflict with federal SEPs and are allowed by the Centers for Medicare and Medicaid Services (CMS) on HealthCare.gov.

- The Marketplace Advisory Committee (MAC) will become a committee of the Oregon Health Policy Board and thus, technically will be under its direction. The Oregon Health Policy Board, a nine-member citizen board, is the policymaking oversight body for the Oregon Health Authority and its departmental divisions. The governor is

required to set the term for each member so that terms are staggered rather than all ending at the same time.

- The MAC annual legislative report will become optional. This change results from the fact that the MAC and the Marketplace currently submit substantially similar reports. This will allow the MAC report to stand out and be less routine or would allow for a combined report.