



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

October 2, 2019
11:00 a.m. – 3:00 p.m.
Labor & Industries Building – Room 260
350 Winter St NE, Salem, OR 97301

Phone: 866-377-3315
Access code: 1947 713
Link to join: ohim.adobeconnect.com/macmeeting-10-02-19/
(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	Discussion, updates, or recommendation	Presenter
11:00 – 11:15 a.m.	Welcome and approval of meeting minutes		Dan Field Committee Chair
11:15 – 11:30 a.m.	COFA Premium Assistance Program	Updates	Nina Remple COFA Premium Assistance Program Manager
11:30 a.m. – 12:00 p.m.	Marketplace outreach and education	Updates	Misty Rayas Marketplace Outreach and Education Manager
12:00 – 12:20 p.m.	Federal health policy movement	Updates and discussion	Stephanie Kennan McGuire Woods Consulting
12:20 – 12:25 p.m.	Public comment		Dan Field Committee Chair
12:25 – 12:45 p.m.	Collect lunch and break		
12:45 – 1:05 p.m.	2020 health insurance plans	Updates	Katie Button Marketplace Plan Management Analyst

1:05 – 1:35 p.m.	Window shopping tool	Updates and discussion	Katie Button Marketplace Plan Management Analyst
1:35 – 1:45 p.m.	Break		
1:45 – 2:00 p.m.	Oregon Health Insurance Survey and SB 889	Updates	Jeremy Vandehey Health Analytics Director, OHA
2:00 – 2:40 p.m.	Open enrollment marketing	Updates and discussion	Elizabeth Cronen Marketplace Communications and Legislative Manager Coates Kokes team
2:40 – 2:50 p.m.	Proposed changes to committee by-laws		Chiqui Flowers Marketplace Administrator
2:50 – 3:00 p.m.	Closing remarks		Dan Field Committee Chair
Adjourn			



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

Meeting Minutes
Wednesday, July 17, 2019 - 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, Cindy Condon, Dan Field (Chair), Jim Houser, Sean McNulty (by phone), Shanon Saldivar (Vice-chair), Sandy Sampson, Cameron Smith (ex-officio), and Jeremy Vandehey (ex-officio by phone)

Members excused: Shonna Butler, Numi Griffith, Ken Provencher, and Jenn Welander

Members not present: Joe Enlet

Other presenters: Stephanie Kennan (by phone)

Marketplace staff: Chiqui Flowers, Administrator; Anthony Behrens, Senior Policy Advisor and Carrier Liaison, Elizabeth Cronen, Legislative and Communications Manager; Cable Hogue, Implementation Analyst and Federal Liaison; Victor Garcia, Operations Development Specialist; and Dawn Shaw, Division Support Coordinator

Other DCBS staff present: Joel Payton, DFR Reinsurance Program Manager; and Tashia Sizemore, DFR Product Regulation Manager

Agenda item and time stamp*	Discussion
Welcome and introductions, committee housekeeping 0:0:00*	Introduced new committee member, Sandy Sampson. She comes to us from the Yellowhawk Tribal Health Center, was a part of Cover Oregon. The committee approved the meeting minutes from April 18, 2019.
2019 Oregon legislative session recap 0:03:40	Elizabeth Cronen discussed the bills that passed and did not pass the 2019 Oregon Legislative session. Jeremy Vandehey provided additional information. <ul style="list-style-type: none">• COFA (Compact of Free Association) Dental, HB 2706 (passed)<ul style="list-style-type: none">○ This most directly affects us and our work. It does not create the program. Directs DCBS to oversee a study on the dental needs of COFA Islanders (Palau, Micronesia, and Marshall Islands). COFA Islanders can live legally in the US, but are not eligible for Medicaid. Oregon's program is first in the nation. They currently have no dental benefits. \$99,000 was appropriated to do the work of the study. Along with the study an RFI to dental care organizations. Report is due April 15, 2020. The advisory committee would likely be consulted after it is completed. Medicaid typically includes dental, this is to make COFA benefits comparable to Medicaid. Chiqui will be the point of contact for this topic.• Health care cost review, SB 889 (passed)<ul style="list-style-type: none">○ Based over at OHA (Oregon Health Authority) and involves a lot of research, analysis, work groups, and task forces to take a look at health

care cost growth. Will be looking at ways to hold down health care costs while still delivering quality health care. It calls for a MAC (Marketplace Advisory Committee) member to be on the implementation committee. There was discussion about how a current member of the MAC committee might serve on the implementation committee given the term limits of those currently on the committee. The goal is to set a growth rate target to help measure who is above and below that target.

- Will start late next year and will go for about a year.
- The DCBS designee will likely be Chiqui Flowers.
- Universal health care, SB 770 (passed)
 - Two components: coming up with a Medicaid buy-in and creating a task force that would develop a plan for a statewide single payer insurance program.
 - Cameron Smith will be a part of the task force.
 - HB 2012 did not pass, but was added into SB 770.
 - Medicaid buy-in will be reported to the legislature next summer (2020).

2020 health insurance rates

0:33:40

Tashia Sizemore provided information on the 2020 health insurance rates.

- In the process of concluding the 2020 plan filing year (rates, forms, and binders) for individual and small group plans. In Oregon we only review the forms for large group plans.
- July 16 publicly released the information about the 2020 proposed rate decisions. Information is available on OregonHealthRates.org.
- DFR (Division of Financial Regulation) had a couple of insurance companies expand into new areas.
- Starting to see stabilization in the market. Rates were lowered, on average, by 1% from the preliminary decisions and 2% from the original requests. On the Individual market, the rate decisions ranged from a 3.2% decrease to an 8.9% increase. Cindy Condon asked what the rate changes were by metal level, rather than the total average change. That information is not available. Small group ranged from a 2.3% decrease to an 11.7% increase.
- Final orders went out Monday, July 15. There is a 21-day period for insurers to request a rate review hearing. They do not anticipate any issues with the rates.
- On a final note, the final rates for 2020 on the individual market lowered the premiums by an estimated \$44 million for consumers [compared to the rates initially filed by carriers¹].
- No indication that there are any network changes.
- Press releases have gone out to inform the public. Cindy Condon said that she felt that the content in the release was misleading. Cameron Smith acknowledged her feedback and indicated that DCBS will mark that for future releases.
- Federal uncertainty and rise of medical costs have been cost drivers for consumers.
- About a year and a half ago, the division applied and received a CMS grant to review the prescription drug formularies. The preliminary work will be coming out. They will be reaching out to the insurers about any adjustments that will be needed and will become part of the filing process.
- There is a public SERFF website (<https://filingaccess.serff.com/sfa/home/OR>) where the public can review the filings which includes formularies.
- Tim Hinkle, a DFR Actuary, created a tool that allows consumers to see what the estimated copay would be for an office visit.

- DFR is making sure that the formularies are meeting CMS requirements and that a class of drugs aren't all on the highest tier which would make them unavailable to most consumers. Also making sure that there are generic drugs available and preventive drugs are covered.
- Tashia is available to chat about any questions or concerns. You can call her, 971-283-0102 or email her at Tashia.Sizemore@oregon.gov.

Federal health policy movement

0:58:30

Stephanie Kennan from McGuireWoods Consulting called in from Washington D.C. to present information about current legislation and cases that involve the Affordable Care Act (ACA).

- The House in May passed a number of bills that combined both drug and ACA legislation, now those bills are in the Senate.
- They combined four bills. One deals with Outreach and Education and the Navigator program.
 - Reverse the cuts in the federal Marketplaces. \$100 million would go to FFMs and \$25 to SBMs. Funds could not be used to promote non-ACA related plans. Reverses some changes the current administration has made to the Navigator program. Would restore having at least 2 Navigators per state. Will make sure that HHS produces a summary about marketing and outreach and the demographic and geographic data.
 - \$2 million in grants for states to create SBMs (State-based Marketplaces). Limits short-term plans. Requires increased transparency.
 - Requires the GAO (Government Accountability Office) to undertake a series of reports. One of which would be to determine if the routine maintenance of HealthCare.gov has disrupted enrollments and consumers ability to get information.
- The House Energy & Commerce Committee had a markup of 26 bills. One was a surprise billing bill to allow federal benchmarking that needs to be paid. An amendment was accepted that would allow any bill \$1,250 or more to get out of arbitration.
- In the Senate, the Health, Education, and Pensions Committee put out a package called the Low-end Health Care Cost Act, most of it was drug pricing and included a surprise billing provision. Was not able to hotline the bill because four senators objected to the surprise billing provision.
- The GAO responded to a letter from Senator Wyden and Congressman Pallone asking if the section 1332 waiver guidance met the criteria for a CRA (Congressional Review Act). The GAO did respond saying it did. The administration needs to send a cost benefits analysis to the GAO and a report to the House and Senate. The House has voted to negate the guidance and the Senate is looking at a way to do the same.
- The Executive Order for Health Care Transparency
 - Required HHS within 50 days to propose a rule for hospitals to post actual charges of shoppable items and services.
 - Required a quality road map in 180 days (around December), HHS, DOJ, VA to align and improve reporting on data and quality measures for in-patient and out-patient measures and eliminate counter productive measures. It includes Medicare, Medicaid, CHIP, VA and Military Health program. The White House is going to have a Quality Summit, date TBA,

and they are looking for 15 stakeholders to talk about how to go about the road map.

- Made three changes to high deductible health plans and HSAs. They are trying to get the plans to cover preventive care before the deductible. The IRS put out guidance today. They are loosening up how the FSAs can be used.
- The Supreme Court is taking up the Risk Corridor case and will be heard in the fall.
- Still awaiting the outcome for Texas v. Azar, could be 60 to 90 days away.

HRA expansion

1:15:48

Anthony Behrens presented an overview of the new federal HRA (Health Reimbursement Arrangement) regulations.

- Pre-regulation HRAs
 - A HRA is an employer-funded group health plan and is funded by the employer. Gives the employee money that is not reported on their payroll taxes and not considered income. The money is to be used for IRS-defined medical expenses. Could not be used to pay for an individual insurance premium.
 - The HRA had to comply with ACA group health plan requirements, had an annual dollar limit on EHBs (essential health benefits), and coverage of preventive services.
 - There was a new regulation that was passed about six months before this HRA rule applied to small business employers (less than 50 FTE employees). It created QSEHRAs (Qualified Small Employer HRAs). It allowed employers to reimburse employees for premiums on individual plans. If the employee group health plan is deemed affordable it is not eligible for premium tax credits and the employee can not opt out and get an individual plan and be reimbursed.
- Post-regulation HRAs made two major changes
 - First
 - Employers with 50 or more employees can integrate individual plans with ICHRA (individual coverage HRA). Includes individual coverage in the individual market and fully insured health insurance. Does not include short-term, limited-duration, coverage consisting solely of excepted benefits, health care sharing ministries, or TRICARE (does not cover ACA EHBs).
 - The employer can define the medical expenses that are reimbursable. The same affordability calculations are followed.
 - Must follow new integration rules to qualify for preferential tax treatment. Protects the individual market from employers dumping sick members on to the individual market.
 - Must be offered on the same terms to employees in the same class (full time/part time, geographic location, salaried/hourly, etc.). A notice must be provided explaining ICHRA and premium tax credits.
 - Procedures must verify employee/dependents are enrolled in an individual plan or Medicare.
 - Opt-out allowance for those eligible for PTCs.

- Can't endorse or receive kickbacks from a carrier, plan or agent.
 - No salary reductions for on exchange plan premiums.
- Second
 - Created an excepted benefits HRA. Employers can fund up to \$1,800 to be used to pay premiums for excepted benefits, short-term plans, and COBRA.
- Special Enrollment Periods – creates a one-time SEP for coverage on and off the Marketplace 60 days before and after a triggering event to select a QHP (Qualified Health Plan).
- Implementation timeline
 - Rule is already in effect.
 - Late summer/early fall HealthCare.gov with assist consumers in determining if an HRA is affordable and if they should apply for tax credits.
 - January 1, 2020 employers can start offering ICHRAs.
 - Late March 2020, SEP verification will be built into HealthCare.gov.
 - May 2020, the HRA tool will include affordability calculation and tax credit eligibility.
- Concerns
 - Risk shifting/dumping of employees with health conditions onto the individual market.
 - Gray-market plans could lead healthier workers to purchase short-term or non-compliant plans which could weaken the individual market.
- Consumer implications
 - Incorrect APTC (advance premium tax credit) determinations.
 - Confusion on purchasing off-Marketplace and potentially resulting in repayment of PTCs.
 - Confusion about requirements resulting in negation of tax benefits for employer.
 - Higher individual premiums due to a sicker individual market.
 - Low-income employee could be ineligible for PTCs if the HRA is deemed affordable.
 - New 3:1 cap will generally benefit younger workers at the expense of older workers.
- Possible state action
 - Marketplace and DFR – educate consumers and brokers about new rules and risks. Will create FAQs.
 - DFR – require disclosures to employers and consumers, broker and insurers to acquire signed consumer attestations. Reduce deceptive marketing.
 - BOLI (Bureau of Labor and Industries) – required notices and employer/employee education.
 - DOR (Department of Revenue) – decouple from HRA provisions of federal tax law.

1:44:36

- The Reinsurance Program is exceeding expectations. The health insurance market in Oregon is competitively stable.
- Have received a lot of support from DCBS, Compliance Teams, Legislative and Fiscal Offices, other states and on outreach there was tribal support to get funds for Measure 101.
- Oregon has done an amazing job in getting the program going, stabilized, increasing enrollment and keeping rates low. Other states have tried to implement a reinsurance program and have failed. Seven states have implemented the program and several others are in the process, despite federal uncertainty of the ACA.
- Purpose State Innovation Waiver, PPACA 1332(1) (c) provide ways to stabilize the individual market. They are granted for five years, come from HHS and Department of Treasury and compliance is handled through CMS (Centers for Medicare and Medicaid Services) and the Insurance Oversight Committee. The waiver must satisfy four guardrails which we have satisfied.
 - Expand coverage throughout Oregon, at least 2 health care exchanges for 36 counties.
 - Affordability – rates average 6.3% lower than without the waiver
 - Comprehensive coverage for ACA compliant plans
 - Waiver must not increase the federal deficit.
- CMS compliance requirements
 - Four quarterly reports
 - Annual report
 - Public forum 10/22/19 at 1 p.m.
 - Additional information available on the CMS.gov website: [cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html)
- Oregon law HB-2391
 - Waiver will go from 1/1/18 to 1/2/23
 - DCBS will collect a 1.5% assessment from PEBB and managed care organizations (MCO) premiums for eight quarters (Measure 101)
 - Pass on funds to OHA to provide Medicaid assistance (\$127 million over five quarters)
 - Retain a portion of funds to reimburse seven eligible health insurers (Moda, Pacific Source, Health Net, Regence, Providence, Kaiser, and Bridgespan) \$90 million
- ORP extension HB-2010
 - Manage ORP 1/1/20 to 12/13/26
 - Collect a 2% assessment from PEBB and MCOs
 - Pass on funds to OHA 4/20
 - Retains \$42 million to reimburse eligible health insurers
- Benefits of the cost sharing
 - Increased choices for consumers
 - Improved quality and lowered health care costs
 - Minimum coverage of at least two carriers per county
 - Reduced cost sharing volatility and long-term stability in the individual market
- Cost sharing mechanisms
 - Attachment points will help pay the insurers half the amount: \$95,000 to \$1 million per member in 2018 and \$90,000 to \$1 million per member in 2019.

- DFR is in the process of verifying and auditing the claims now, there was a July 15 deadline for insurers to submit their claims. Will try to get the reimbursements to carriers by October.
 - An example is a charge for \$295,000, attachment point starts at \$95,000. \$200,000 will be shared between the state and the insurer. The insurer will be reimbursed \$100,000.
- Current and future funding
 - Oregon Transitional Reinsurance Pool CY 2016
 - Oregon Health Insurance Marketplace CY 2017
 - CMS pass-through funding 2018-2026
 - Assessment of 1.5% from individual health benefit plans 2018-2019
 - HB-2010 2% assessment from individual health benefit plans 2020-2026
- Future opportunities and challenges
 - Expand coverage throughout Oregon
 - Maintain affordable prices and increase enrollment
 - Offer additional comprehensive coverage options
 - Market stabilization
- Data is located on the DFR website
dfr.oregon.gov/business/reg/health/Pages/oregon-reinsurance-program.aspx

2019 Marketplace request for information

Victor Garcia presented updated information along with Shanon Saldivar and Stephanie Castano on the 2019 RFI (request for information) process for a state-based marketplace (SBM) and consumer assistance center.

2:08:10

- Progress update on other transitioning states
 - Nevada – beginning user acceptance testing with external stakeholders. They tested the data migration from HealthCare.gov worked, and it did. On track for OE 2020 go-live date.
 - New Mexico – completed RFP, vendor selected in June with an OE 2021 implementation. Different vendor than Nevada.
 - New Jersey and Pennsylvania – both planning on going from full FFE to full SBM, preparing for OE 2021 go live. This is a transition that we have not seen before. They are planning on releasing the RFP at the end of this month (July).
 - Oregon RFI overview and results
 - Borrowed heavily from Nevada's RFI, so we didn't reinvent the wheel. Closed May 31, 2019.
 - Two-part RFI: part one – technology platform (enrollment platform and website) and part two – consumer assistance center (a third-party call center).
 - Had responses from ten vendors: two for part 1, four for part 2, two for both parts, and two for ancillary services (offered telephone/referral services).
 - Results
 - Technological stability – talked a lot about this last meeting. Details are similar to the RFIs from NV and NM. Vendors making improvements to existing platforms. Oracle is mentioned a lot.
 - Questions we added for Oregon was around the Marketplace/OHP relationship and making sure the customer
-

service agents have knowledge and training to avoid complaints that we get about HealthCare.gov.

- Price will depend on the features and was not expected to get information about in the RFI process.
- Technology
 - Data exchange between the Marketplace/ONE system can benefit. Was looking to see if we could duplicate the functionality of HealthCare.gov. We talked to DHS/OHA technology reps to make sure we were using the right description of the ONE system.
 - Data migration concerns, only one vendor had experience, but all had sound proposals.
 - Ongoing improvements – now that they have stable platforms they are looking to make improvements like IVRs (interactive voice recording) and chat bots, can automate processes instead of calling a call center to do things like password changes. Possibility of premium payments and carrier reconciliation component.
- Consumer assistance center (CAC)
 - We have a high level of standards for customer service and the call center staff would have to have the same when talking to Oregonians. There were variances in recommended staffing levels and smaller than the NV RFI.
 - Offered complete solutions: office space, software, and staffing.
 - CAC only vendors were willing to adapt to any technology platform we would go with, however they are not QHP-dedicated.
 - Some vendors showed they had a deeper understanding of Oregon mission and value priorities.
- Takeaways
 - Good vendor competition gives us more options.
 - The vendors have proven technology success and will continue to improve over time.
- We are debating on whether or not to bundle the technology with the CAC. Separate contracts would require more complex project planning.
- Benefits for Oregon to switch to a full SBM
 - We would have control over enrollment, customer service, and operations.
 - Medicaid buy-in via exchange.
 - Premium assistance programs like COFA.
 - Ownership of data, we currently do not have ability to get the data we need, just have what CMS gives us.
 - Length of open enrollment periods.
 - Complex case resolution would be easier.
 - Predictability of cost, knowing what we are paying for.
 - Stakeholder (carriers, agents, assisters, and other agencies) benefits
 - Improved communication.
 - Dedicated portals and consumer assistance tools.

- Quickly implement improvement ideas.
- Risks for switching to a full SBM
 - Potential of technology failure due to past experience.
 - Mitigated by deliverables-based contracts (not paying until the project is done), project checkpoints, previous experience, and quality assurance (QA) transparency (we would have an independent QA vendor).
 - Scope creep
 - Mitigated by a mindful of set control process, boundaries, roadmap/progression path, and QA transparency.
 - Changes to federal laws, rules, and policies
 - Mitigated by collaborative relationships with other SBMs.
 - Uncertain timelines
 - Mitigated by engaging early with oversight entities.
- Costs for switching to a full SBM
 - Spending limited to the legislatively approved budget and activities.
 - Carriers currently pay FFM fee directly and we do not.
 - Required Marketplace staffing changes.
 - Pre-RFP development and contracting costs.
 - Services from other state agencies (Procurement, DOJ, OSCIO).
 - Consultants, QA contractors, grants for consulting (RWJ State Network, etc.).
 - Vendor flexibility to work around state budget cycles and options to adjust features for affordability.
 - Affordability
 - External CAC savings for state implementation
 - Predictable costs with transparent accounting
 - Single Marketplace assessment for insurers
 - Projected lower overall costs and improved outcomes for consumers and stakeholders
- Evaluation criteria
 - Improved outcomes and service for Oregonians
 - Better alignment with statutory intended purpose
 - Ownership and accountability for enrollment data and related metrics.
 - Lower overall costs
- Timelines
 - Vendors estimate time from RFP to OE is 18 months
 - Dependent on:
 - Stakeholder reception
 - Legislative, including Legislative Financial Office approval
 - State and federal oversight requirements
 - Milestone completion dates
 - Soonest most likely 21-23 biennium
- Next steps
 - More detailed estimates, early indicators justify a switch.
 - Stakeholder engagement through existing channels with carriers and agents.
 - Business case with cumulative results of preliminary analyses.
 - Observe other state efforts, successes and lessons learned.
- MAC discussion and recommendations on next steps
 - Questions on if agents or carriers will realize revenue loss.

- The transition year planning will have to account for paying for the existing system while developing the other.
- The FFE is dropping the user fee by 0.5%, going from 3% to 2.5%. However, premiums will likely go up by more than 0.5%, which means the amount paid for the fee is still likely to increase
- We are not looking for an integrated Medicaid eligibility system, we already have one and we are looking to integrate with the current system. Will likely improve transfer of files. Could have more open lines of communication with OHA to resolve issues quicker.
- Recommendation is to move forward to the RFP.
- One concern is that HealthCare.gov seems to be easy to use and will hope that the new system will be just as easy.
- Cameron Smith went over the internal steps and to be aware of timeframes.
- Requested drafting a letter advising DCBS and the Marketplace to move forward with planning for an RFP.

Key meeting takeaways

Elizabeth Cronen seeking information from the MAC members on what they feel are the key takeaways or items that were discussed and not resolved from each meeting to help her in compiling the next MAC annual report.

3:18:21

- Chiqui recommended that the takeaways be sent to Elizabeth via email after there is some time for reflection.
- Recommendation was to have the minutes sent out within a few weeks of the meeting so the information is still fresh in our minds so we can provide the takeaways. Dawn agreed to do so.
- Those interested in serving on the taskforce looking at the causes and possible solutions to mitigate the growth of healthcare costs (SB889) should let Chiqui know.

Closing

Next meeting will be September 18.

7/31/19 update: looking to change this date due to Legislative Days and SBM/SBM-FP meetings with congressional staff in DC. Chiqui has sent out an email with a survey on which dates the committee would prefer.

1. Additional context added based on the following DFR press release:

<https://dfr.oregon.gov/news/2019/Pages/20190715-2020-final-rates.aspx>

Overall individual rates are increasing, but the increase approximately \$44m less than what was submitted in the initial rate filings.

*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 2019 Meetings, July 17.

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

COFA Premium Assistance Program



- 2017 - 443 approved enrollments
 - \$182, 939 premiums paid
 - \$1.7 million paid claims by carriers
- 2018 – 672 approved enrollments
 - \$216,419 premiums paid
 - \$3.4 million paid claims by carriers
- September 2019 - 705 approved enrollments
- Jan – June premiums \$181,944.87 paid
- Jan – June \$756,924.19 paid claims by carriers

1

COFA Premium Assistance Program



2019 Enrollment by county

Marion/Polk	55%
Metro Tri-County	34%
Union/Umatilla	8%
Remaining counties	3%

2019 Enrollment By Country

Federated States of Micronesia	51%
Republic of the Marshall Islands	34%
Republic of Palau	4%

2

COFA Premium Assistance Program



2019 Enrollment By age

19 – 30 years	149
31 – 39 years	125
40- 49 years	125
50– 64 years	205
65 and older*	113

*oldest applicant is 92

3

COFA Premium Assistance Program



COFA Program videos

- Available in 5 languages posted to oregonhealthcare.gov/cofa:
 - English
 - Chuukese
 - Marshallese
 - Palauan
 - Pohnpeian
- Topics include:
 - Who should apply for the program
 - How to apply to the COFA program
 - How to use your insurance
 - How to get reimbursed for out-of-pocket costs

4

COFA Premium Assistance Program



Enrollment events

- Six enrollment events are scheduled throughout the state:
 - La Grande
 - Salem
 - Portland-metro area (Clackamas, Multnomah, Washington)
- We are hoping to schedule more community enrollment events with the use of outreach liaisons embedded in the community

5

Outreach Customer Service Center Partner Agent Program Community Partner Program



Outreach & Strategy Pre-2020 Open Enrollment/Plan Year



Outside open enrollment 2019 for Plan Year 2020 Outreach Team supports:

- Statewide- outreach and education events: Which include but are not limited to, events that draw millennials, events that are tribal focused, Latinx events, Russian cultural events, Rural events (Eastern Oregon now has a dedicated- Outreach Coordinator) events that may draw APTC-eligible, Health Fairs, College Resource events, Runs, Rodeo's, Fairs, Festivals, Wedding Shows, School events.

2

Outreach & Strategy Pre-2020 Open Enrollment/Plan Year



- Rapid Response and Trade act sessions with Employment Office and the WorkSource office.
- Training- offered statewide for consumers- Marketplace 101 and Marketplace Building Blocks.
- Facilitate Oregon specific statewide Community Partner Certification Training.
- Co-present and attend Statewide Collaborates with OHA partner.
- Attend Statewide Service Integration meetings- Monthly.
- Meetings with Agents and Community Partners throughout the State.

3

Outreach & Strategy Pre-2020 Open Enrollment/Plan Year



Dedicated Tribal Liaison for Tribal Outreach

Listed are some of the outreach we have done or will be supporting August-October 2019

- SB 770 Health Cluster
- Tribal site visits often accompanied by SHIBA felid officers
- Tribal community event in Grand Ronde – tabling at event
- Tribal community event in Pendleton – tabling with Yellowhawk

4

Outreach & Strategy Pre-2020 Open Enrollment/Plan Year



Tribal Outreach, continued

- Meeting with Siletz tribal health staff to discuss Tribal Premium Sponsorship (TPSP) and ACA cost protections for AI/ANs
- Assister training at Yellowhawk, CTCLUSI, Warm Spring & Cow Creek, Klamath
- Assister training and Basic assister training and ACA cost protections discussion at Grand Ronde
- ONAC networking luncheon – presented on ACA cost protections and TPSP
- Jim Pepper 7th Annual Native Arts Festival - Portland
- Community Baby Shower event in Warm Springs

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Outreach & Strategy Pre-2020 Open Enrollment/Plan Year



Outreach Events: Pre- Open Enrollment 1/1/2019- 8/31/2019

- Events = 238
- Sponsorships = 60

* Does not including trainings, collaborates or general required outreach in regions or regional specific outreach*

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Outreach Strategies & Customer Service 2020 Open Enrollment



Outreach Events: Open Enrollment 11/1/2019-12/15/2019 (scheduled to date)

- Outreach Events = 14
- Enrollment Events = 5
- Sponsorships = 9

Does not including trainings, collaborates or general required outreach in regions or regional specific outreach, CP Enrollment events or Agent Enrollment events

7

Marketplace Customer Service Center



- Provides Oregonians with information and local resources using Oregonhealthcare.gov (supported by Outreach team).
- Helps consumers walk through Healthcare.gov if needed.
- Call center maintains a 85% or better customer service level outside and during open enrollment.

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Marketplace Customer Service Center



- Call center 2019 OE- customer satisfaction survey 99% of our customers were extremely satisfied with the customer service they received.
- Outreach team provides detailed support to consumers for escalated and urgent issues via Constituent Issues Liaison.

9

Marketplace Customer Service Center- Constituent Issues



Listed below are common issues and the average days to resolve with the FFM:

- Adding a child to the current plan through SEP: 2 cases, one resolved in 160 days, the other is currently in appeals at 163 days
- Issues with correcting 1095-As taking months to resolve
- SEPs for two consumers newly residing in Oregon: FFM taking much longer than the two-week maximum to review verification documents (minimum of six weeks), and resulting in expiration of SEP deadline, having to go to appeals because it could not be resolved by HICS escalation.

10

Marketplace Customer Service Center- Constituent Issues



- Plan erroneously flipping back to lower metal tier every time they update their application during the plan year
- Sending application data to OHP/CHIP for determination for a household at just under 400% of FPL, causing delays in adding child.
- Canceling plan on the wrong date when consumer calls to cancel due to impending Medicare coverage.
- General: lack of consistency/accuracy in requesting assistance from FFM for escalations, in terms of what can actually be done, what level staff has authority to make the change, etc.

11

Partner Agent Program: PY2020



- 32 partner agencies awarded grants this year.
- Total grant awards to partner agencies: \$314,500.
- Over 1/3 of our partner agencies are bilingual with assistance available in Spanish, Thai and Chinese.
- Maintained good overall geographic coverage.
- Still working toward a partner presence in SE Oregon.

12

Plan Year 2019/2020 Comparison



- We awarded 32 partners this year vs. 33 last year.
- Total partner agency grants awards down \$7,000 from \$321,500 last year to \$314,500 this year.
- Increased reach and visibility, despite the decrease in number of partners and grant dollars spent.
- Number of bilingual agencies continues to increase significantly, year over year.
- Improved process for ordering of marketing supplies/signage will help visibility for PY2020.

13

2019-2020 CP Grantees



OHIM has contracts **with eight organizations** to provide outreach and enrollment assistance to consumers in Oregon from August 2019 through July 2020.

- **Benton County Health Services** (Corvallis) - new grantee
- **Cascade AIDS Project** (Portland) - returning grantee
- **Interface Network** (Salem) – returning grantee
- **Immigrant & Refugee Community Organization** (Portland) – new grantee
- **Latino Community Organization** (Bend) – new grantee
- **Northeast Oregon Network** (LaGrande) - returning grantee
- **Project Access NOW** (Portland) - returning grantee
- **The Rinehart Clinic** (Wheeler) - returning grantee

For this grant year, all awards **total \$419,250**. Grants are awarded after an open and competitive process.

14

PY 2020 Marketplace Training



- **OHIM refined its Marketplace assister training** in Plan Year 2020, offering in-person and webinar versions of the training for the second year.
- **OHIM also offered training and certification exclusively in Spanish** for the first time this year.
- **The Oregon-specific training was created in response to feedback** that the HealthCare.gov training offered by CMS was creating additional barriers for community partners.
- **Oregon is the first state in the nation to transition its training** in this manner.

15

PY 2020 Marketplace Training



The training includes two tiers:

- **Basic Marketplace training:** a one and a half hour training providing information on the ACA, health insurance concepts, and the financial assistance programs available on the Marketplace. This tier is intended for any person who provides health coverage assistance (OHP or QHP).
- **Advanced Marketplace training:** A roughly four hour presentation which illustrates the specific duties of a Marketplace Assister, including: applications, comparing plans, service equity, post-enrollment follow-up, preventing fraud, appeals, and security/privacy, among other topics.

16

PY 2020 Marketplace Training



- **Completion of both Basic and Advanced courses are required** to assist consumers with HealthCare.gov enrollment.
- **Advanced also requires** attendees to complete a **35 question post-training quiz** for certification.

17

PY 2020 Marketplace Training



Since July 2019:

539 community partner assisters have received at least Basic training throughout the state.

- **249** have attended Basic only.
- **377** have attended both Basic and Advanced.
- **790** have registered for all trainings, with **74** registered for upcoming trainings and **251** no-shows (31%) – this could be due to trainees registering for multiple training sessions and showing up to only one.

18

PY 2020 Marketplace Training



50 trainings have been provided by the Marketplace team in-person at locations throughout the state as well as via webinar as of this writing.

- As of 9/23/19, **306** people have passed their certification exam and are available to assist Oregon consumers with Marketplace applications.

20

PY 2020 Marketplace Training



The Marketplace outreach team also held community-specific trainings with assisters that serve hard-to-reach populations:

- **This includes three trainings held in Spanish** (in person and via webinar) with 14 Latinx-focused assisters attending.
- **This also includes three sessions held at tribal clinics** with 10 tribal assisters attending.

20

PY 2020 Marketplace Training



The Marketplace also offers supplemental trainings on other topics, open to our grantee and non-grantee CPs, available throughout the year:

- Assisting immigrant populations with QHP applications.
- Entering income and calculating affordability for QHP applications.
- Transitioning between OHP/QHP and QHP/OHP.
- From Coverage to Care.
- Special Enrollment Periods.
- Appeals (*planned but not yet scheduled*).

21

2020 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	7	Moda	3	0
		Providence	4	1
Benton	30	BridgeSpan	7	2
		Kaiser*	10	1
		PacificSource	9	1
		Providence	4	1
Clackamas	43	BridgeSpan	8	2
		Kaiser	10	1
		Moda	9	1
		PacificSource	9	1
		Providence	7	1
Clatsop	20	BridgeSpan	7	2
		Moda	9	1
		Providence	4	1
Columbia	30	BrideSpan	7	2
		Kaiser	10	1
		Moda	9	1
		Providence	4	1
Coos	13	Moda	9	1
		Providence	4	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Crook	16	Moda	3	0
		PacificSource	9	1
		Providence	4	1
Curry	13	Moda	9	1
		PacificSource	9	1
		Providence	4	1
Deschutes	23	BridgeSpan	7	2
		Moda	3	0
		PacificSource	9	1
		Providence	4	1
Douglas	7	Moda	3	0
		Providence	4	1
Gilliam	7	Moda	3	0
		Providence	4	1
Grant	7	Moda	3	0
		Providence	4	1
Harney	7	Moda	3	0
		Providence	4	1
Hood River	26	Kaiser*	10	1
		Moda	9	1
		Providence	7	1
Jackson	13	Moda	9	1
		Providence	4	1
Jefferson	16	Moda	3	0
		PacificSource	9	1
		Providence	4	1
Josephine	13	Moda	9	1
		Providence	4	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Klamath	7	Moda	3	0
		Providence	4	1
Lake	7	Moda	3	0
		Providence	4	1
Lane	33	BridgeSpan	7	2
		Kaiser*	10	1
		Moda	3	0
		PacificSource	9	1
		Providence	4	1
Lincoln	11	BridgeSpan	7	2
		Providence	4	1
Linn	30	BridgeSpan	7	2
		Kaiser*	10	1
		PacificSource	9	1
		Providence	4	1
Malheur	7	Moda	3	0
		Providence	4	1
Marion	23	Kaiser	10	1
		Moda	9	1
		Providence	4	1
Morrow	7	Moda	3	0
		Providence	4	1
Multnomah	43	BridgeSpan	8	2
		Kaiser	10	1
		Moda	9	1
		PacificSource	9	1
		Providence	7	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Polk	23	Kaiser	10	1
		Moda	9	1
		Providence	4	1
Sherman	7	Moda	3	0
		Providence	4	1
Tillamook	20	BridgeSpan	7	2
		Moda	9	1
		Providence	4	1
Umatilla	7	Moda	3	0
		Providence	4	1
Union	7	Moda	3	0
		Providence	4	1
Wallowa	7	Moda	3	0
		Providence	4	1
Wasco	13	Moda	9	1
		Providence	4	1
Washington	43	BridgeSpan	8	2
		Kaiser	10	1
		Moda	9	1
		PacificSource	9	1
		Providence	7	1
Wheeler	7	Moda	3	0
		Providence	4	1

County	Total plans per county	Carriers in the county	Number of plans per carrier	Number of HSA plans per carrier
Yamhill	32	Kaiser	10	1
		Moda	9	1
		PacificSource	9	1
		Providence	4	1

* Kaiser does not cover all zip codes within this county

What's New for 2020

Katie Button
Plan Management Analyst



County Expansions

Carriers are moving back into counties in 2020

- BridgeSpan is moving back into Benton, Clatsop, Deschutes, Lane, Lincoln, Linn, and Tillamook Counties
- Moda is moving back into Douglas County
- PacificSource is moving back into Benton, Crook, and Linn Counties

2

County Expansions, Continued

- Two counties will have two more carriers than 2019
- Nine counties will have one more carrier than 2019
- All counties will have at least two carriers in 2020

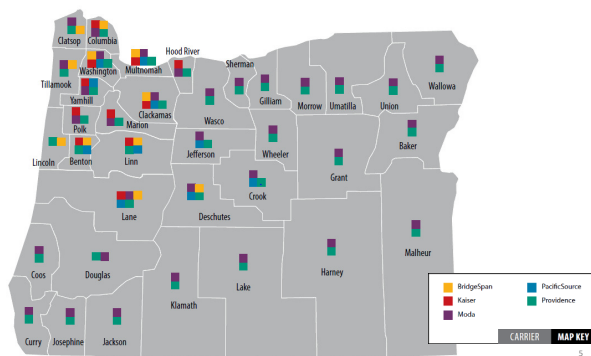
3

New Plans

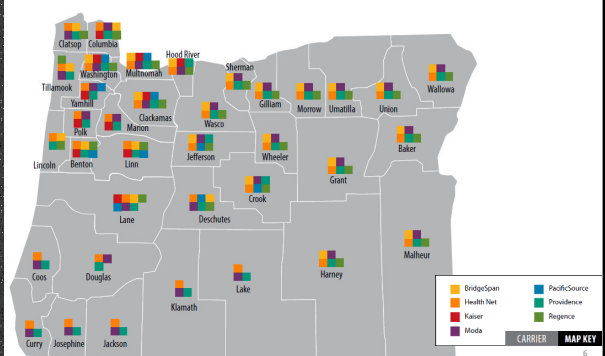
- BridgeSpan, Moda, PacificSource, and Providence are offering new plans in 2020
- Sixteen counties will have more plans than in 2019
- All counties will continue to have at least one HSA-eligible plan

4

2020 On Exchange Carriers by County



2020 Off Exchange Carriers by County



2020 Oregon Standard Bronze Plan



- The 2020 Oregon Standard Bronze Plan has been adjusted to include benefits that can be accessed prior to paying deductible.
- All carriers are required to offer the Standard Bronze Plan in every county in their service areas.

7

2020 Oregon Standard Bronze Plan



2019 Standard Bronze	2020 Standard Bronze
Deductible - \$6550	Deductible - \$7900
Maximum Out of Pocket (MOOP) - \$6650	Maximum Out of Pocket (MOOP) - \$7900
Primary Care Office Visits - No Charge After Deductible	Primary Care Office Visits - \$45 per visit
Other Practitioner Office Visits - No Charge After Deductible	Other Practitioner Office Visits - \$45 per visit
Specialist Office Visits - No Charge After Deductible	Specialist Office Visits - \$90 per visit
Mental/Behavioral Health Office Visits - No Charge After Deductible	Mental/Behavioral Health Office Visits - \$45 per visit
Substance Abuse Disorder Office Visits - No Charge After Deductible	Substance Abuse Disorder Office Visits - \$45 per visit
Physical Therapy Office Visits - No Charge After Deductible	Physical Therapy Office Visits - \$45 per visit
Occupational Therapy Office Visits - No Charge After Deductible	Occupational Therapy Office Visits - \$45 per visit
Speech Therapy Office Visits - No Charge After Deductible	Speech Therapy Office Visits - \$45 per visit
Generic Drugs - No Charge After Deductible	Generic Drugs - \$15 per fill

Oregon Window Shopping 2020

Katie Button
Plan Management Analyst



Background and Problem

Limitations of HealthCare.gov's plan display

- No control over which benefits are displayed
- No ability to edit text of definitions, descriptions, etc.
- Incorrect plan data cannot be updated quickly
- Incomplete information displayed to consumers

Background and Problem, Continued

- State-based exchanges have much more control over plan display
- How can Oregon provide better information to consumers while we use HealthCare.gov?

Procurement

- 2017 and early 2018 – analysis of other states' window shopping tools
- Summer 2018 – begin procurement process
- April 2019 – RFP released
- July 30, 2019 – contract with Consumers' Checkbook signed

Advantages of Consumers' Checkbook's Product

- Standardized template makes implementation simple and efficient
- Ability to configure text and benefits to better help Oregonians
- Ability to add additional functionality in future years

Benefits to Oregonians

- Assistors who work with consumers who aren't eligible for Medicaid can provide APTC estimates
- Links are static, so consumers can share links with others and maintain the eligibility parameters they've entered
- Members of federally recognized tribes can see the plan variants for which they may be eligible
- Consumers can save the plan they like best as a PDF to refer to during enrollment

Outreach and Education Roll Out



- 10/7/19 – 10/11/19 – Webinars for agents and community partners
- 10/15/19 – Rearrange OregonHealthCare.gov homepage to prominently display link to window shopping
- 10/15/19 – E-mail to current Marketplace enrollees letting them know window shopping is available

7

Outreach and Education Roll Out, Continued



- Late October – Include a description of the display in Marketplace Open Enrollment press release
- 10/23/19 and 10/28/19 – Pop up events in late October where consumers will be introduced to the tool
- October and November – Include availability of display in Marketplace social media posts

8

Coverage and Cost Update: Oregon Health Insurance Survey & Sustainable Health Care Cost Growth Target

Marketplace Advisory Committee
October 2, 2019

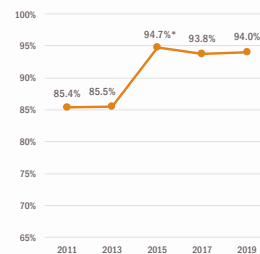
Jeremy Vandehey
Director, Health Policy and Analytics Division
Oregon Health Authority



2019 Oregon Health Insurance Survey

94% of Oregonians were insured in 2019.

Point-in-time health insurance coverage rate, 2011-2019 OHIS



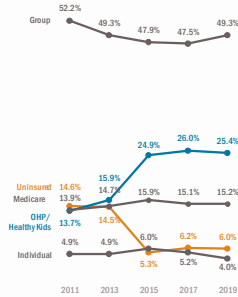
* statistically significant difference from the previous year at 90% confidence level.

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Insurance coverage remained relatively steady in all categories between 2017 and 2019.

Point-in-time health insurance coverage rates, 2011-2019 OHIS

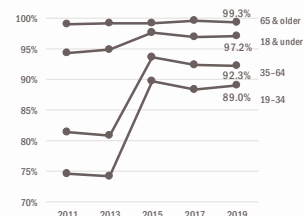


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In 2019, 89% of young adults had health insurance coverage.

Point-in-time health insurance coverage rates, 2011-2019 OHIS



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Future deep dive analysis of results

- Cost of health care
- Access to health care
- Reasons for being uninsured
- Race and ethnicity disparities
- Underinsurance
- County and region
- Dental coverage and access
- Prescription drug utilization and costs

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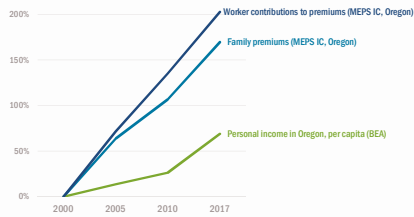
Cost: What's the problem?

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Private sector cost growth is unsustainable

Since 2000, Oregon employer-sponsored insurance premiums have grown three times faster than **personal income**.



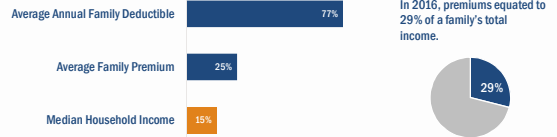
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Health care is increasingly unaffordable

Premiums and deductibles are growing faster than **household income**.

Percent change: 2010-2016



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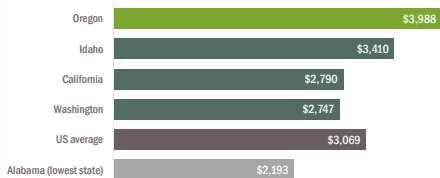
Source: "The Burden of Health Care Costs for Working Families" Penn LDI, April 2019



Oregonians' deductibles are the 3rd highest in the nation

Oregon is 4th highest in the country for the percent of individuals with high out of pocket costs relative to their income.

Deductibles in **Oregon** are higher than in neighboring states.

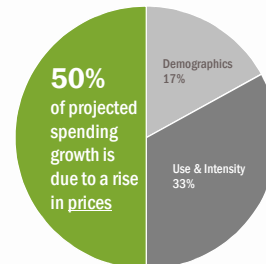


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Source: "The Burden of Health Care Costs for Working Families, a state-level analysis," Penn LDI, April 2019



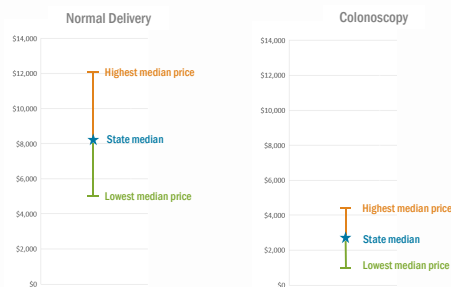
Health care costs are projected to grow to 19.4% of GDP by 2027. What's driving costs?



Source: Stokes et al., "National Health Expenditure Projections, 2019-2027: Economic and Demographic Trends Drive Spending and Enrollment Growth," Health Affairs, 2019.



Commercial prices for care vary significantly.



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Source: OHA 2016 Hospital Payment Report



What's the proposed solution?

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Set a budget target for health care.

A cost growth **target** for the annual rate of growth of **total health care spending** in the state.

The target will align with state economic growth.

Oregon will be the **fourth state** to set a statewide health care cost growth target.

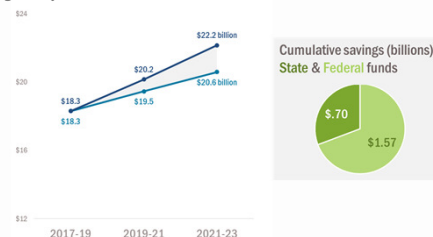


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State programs are already subject to a cost growth target.

OHP, PEBB and OEBB are required to limit the per capita annual growth rate to 3.4%. By doing so they will save the State almost \$700 million.



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There is not a similar cost growth target for the commercial and self-insured markets.

Insurers have limited negotiating power, especially in consolidated markets, **where prices are highest**.

Without a mechanism to protect against high annual cost growth, **costs continue to be shifted to consumers**.

Setting a budget target creates a common goal and mechanism to **reduce total cost growth**.

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What will this mean for health plans and providers?

The target will constitute an expected **ceiling** on per capita cost growth at the state level.

Health plans, providers – and the State – will be expected to **take action** to ensure the target is not exceeded.

OHA will annually report on state-level performance against the target, but also on **performance** at the health insurance market, insurer, and (large) provider levels.

The program will provide better information on **costs & cost drivers**.

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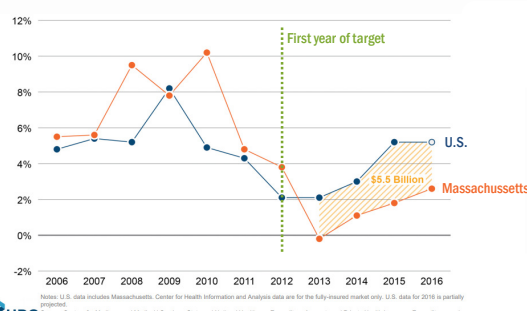
Will it work? (and why?)

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Mass. Cost Growth Target Experience

In recent years, **growth in spending on private health insurance in Massachusetts** has been consistently **lower than national rates**.



What will drive success?



Common goal

Payers and providers are publicly responsible for reducing health care cost growth.



Sustainable target

Selecting a target that ensures health care costs do not outpace other economic growth, such as general inflation or wages.



Transparency

Reasons for cost growth are studied and publicized, informing policy recommendations.



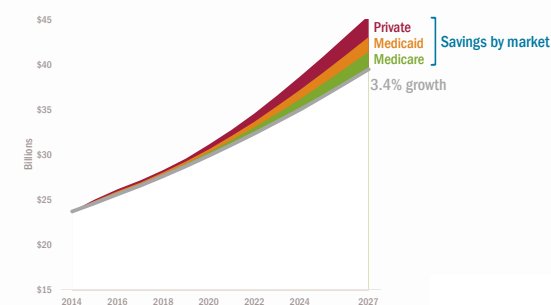
Total cost of care approach

Taking a total cost approach allows payers and providers to shift from volume to value-based approaches.



Oregon would save \$29 billion between 2018-2027 if the 3.4% target applied statewide.

When compared to CMS's projected per capita cost growth of 4.7%



Notes: Medicaid enrollment growth projected to be 2% annually. Source: Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Will

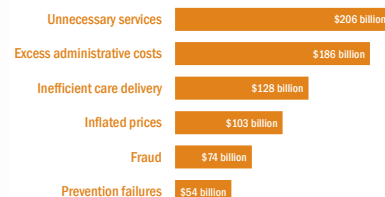
access & quality
be compromised?

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There's room to save and improve quality.
Legislation requires that quality remain central to the discussion.

The Institute Of Medicine estimates there's **\$750 Billion** in annual waste in the health care system.



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Source: "The Healthcare Imperative: Lowering Costs and Improving Outcomes," Institute of Medicine 2010



What are the

next steps?

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SB 889 Establishes the Sustainable Health Care Cost Growth Target program



Creates a framework and key functions of the cost growth target program.



Establishes an Implementation Committee under the Oregon Health Policy Board to develop program details.



Requires an Implementation Plan to the Legislature in September 2020.

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Next Steps

- Implementation Committee will begin meeting in November 2019.
- Membership is defined in SB 889. Members are appointed by Governor Brown.
- The Committee will make recommendations on:
 - the methodology for setting the cost growth target
 - how performance against the target will be assessed
 - how the contributors of cost growth are publicized
 - how quality of care should be measured
- Committee will submit proposed plan to OHPB in summer 2020.

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Contact Information

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(971) 304-8433

Jeremy.Vandehey@state.or.us



26

Open enrollment marketing plans

- Designed to fill gaps in federal approach
- Research based, data informed
- Balanced between new and reused creative elements
- Multicultural
- Statewide

1

Supplements federal marketing

Tactics

Digital

- Search
- Social
- Video
- Website ads

Direct

- Email
- Text message
- Auto dial

2

Supplements federal marketing

Federal messages

"Now Open"

- Healthcare.gov is the place to shop for plans and enroll in coverage.
- Now is the time to shop and compare plans.

"Coverage"

- Get covered. Find a health plan today.
- Enroll now. Get covered.

"Deadline" Message

- Final deadline December 15
- Time's running out. Enroll by the deadline.

3

Guided by research

- Seven focus groups
- Six cities
- Two focus groups in Spanish
- 63 total participants
- Themes:
 - Concerned about deductibles and access to care
 - Frustrated with complexity
 - Cost is a barrier to coverage (\$127 is average considered "fair.")

4

Informed by data

Key counties:

- Multnomah County: 23,593 subsidy eligible and uninsured
- Washington: 18,869
- Marion: 11,990
- Lane: 10,349
- Deschutes: 8,376
- Jackson County: 7,785
- Linn and Benton: 6,624

5

Informed by data

- All subsidy eligible but not insured: 83,840
- Subcategories:
 - Between 200-250 FPL: 20,102
 - Age 19-34: 51,188
 - Men: 75,618 (vs. ≈ 48K women)

6

Reusing some creative elements



7

Producing some new creative

The Basics

- Qualifying incomes, net premium at certain income level, benefits before deductible

The Entrepreneur

- To appeal to self-employed people

Testimonials

- To bring the program to life

8

Multicultural

- The Basics in Spanish audio
- Teresa ad in Spanish video
- A testimonial video in Spanish
- Spanish-language print and web ads
- Spanish outdoor advertising
- Russian radio
- Russian print and web ads

9

Statewide

Huge digital footprint

- Search engine ads, website ads, digital video like Hulu and more, social media video, streaming audio
 - Terrestrial radio in multiple markets
 - Community newspapers
 - Four Oregon markets, plus others
 - Outdoor in high eligibility areas

10

Metrics

Traffic to OregonHealthCare.gov

- Most recent OE: 158,440, \approx 4,000 per day

Traffic known to be male web users

- Most recent: 45.64 percent

Traffic known to be age 25-34

- Most recent: 29 percent

Enrollments among 200-250 FPL

- Most recent: 19 percent

11

**INITIAL RESOLUTION OF THE ADVISORY COMMITTEE
OF THE OREGON HEALTH INSURANCE EXCHANGE**

WHEREAS, Senate Bill 1, a legislative act of 2015 abolishing the Oregon Health Insurance Exchange Corporation and transferring it's duties and functions to the Oregon Department of Consumer and Business Services (DCBS), was enacted by the Oregon Legislative Assembly and signed into law by the governor on March 6, 2015;

WHEREAS, DCBS created the Oregon Health Insurance Marketplace, a division of DCBS, to administer the functions and duties transferred from the Oregon Health Insurance Exchange Corporation;

WHEREAS, under the governing legislation, the governor has appointed the members of the Health Insurance Exchange Advisory Committee, hereafter referred to as 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 the 7th day of April 2016, by the Marketplace Advisory Committee of the Oregon Health Insurance Marketplace.

Dan Field
Committee Chair

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.
- **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).
- **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.
- **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.
- **CCIIO:** U.S. Department of Health and Human Services; Centers for Medicare and Medicaid Services; Center for Consumer Information and Insurance Oversight.
- **CMS:** U.S. Department of Health and Human Services; Centers for Medicare and Medicaid Services.
- **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.
- **Marketplace Advisory Committee:** The committee is the advisory body, also referred to as the Health Insurance Exchange Advisory Committee, established by the 2015 legislation creating the Oregon Health Insurance Marketplace.
- **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.
- **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 or a division 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 three consecutive terms of service.

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

Section 4: The Chair and Vice Chair are elected by committee. In lieu of an election, the committee may choose to request these positions to be appointed by the director of the Department of Consumer and Business Services.

Section 5: 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 6: Committee members serve without compensation but are entitled to travel expenses as outlined in ORS 292.495.

Section 7: 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 8: 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 9: 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.

History of amendments to bylaws:

- April 7, 2016 – Initial approval
- June 4, 2018 – Revised title, updated with information of abolishment of the Oregon Health Insurance Exchange Corporation and creation of the Oregon Health Insurance Marketplace, sections reordered alphabetically, CMS definition added, Article 3, Section 1 added division director.
- October X, 2019 – Revise term limits

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