



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

January 23, 2020
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: 1947713
Link to join: ohim.adobeconnect.com/mac-01-23-2020/
(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	Discussion, updates, or recommendation	Presenter
11:00 – 11:15 am	Welcome and approval of meeting minutes		Dan Field Committee Chair
11:15 – 11:45 am	Health care priorities and future plans	Updates and discussion	Rep. Andrea Salinas District 38 Oregon Legislature Rep. Alissa Keny-Guyer District 46 Oregon Legislature (by phone)
11:45 am – 12:30 pm	DFR panel: <ul style="list-style-type: none">• Oregon Reinsurance Program• Planned changes for the 2021 rate filing process• 2020 legislative session bills	Updates and discussion	Andrew Stolfi Insurance Commissioner and DFR Administrator Tashia Sizemore DFR IPRC – Life and Health Section Manager Jesse O'Brien DFR Senior Policy Advisor
12:30 – 12:35 pm	Public comment		Dan Field Committee Chair

12:35 – 12:55 pm	Collect lunch and break		
12:55 – 1:15 pm	Federal health policy movement	Updates and discussion	Stephanie Kennan McGuireWoods Consulting
1:15 – 1:35 pm	Marketplace Assessment Refund Rule	Hearing	Anthony Behrens Marketplace Senior Policy Advisor and Carrier Liaison
1:35 – 1:55 pm	2020 Open enrollment data analysis	Updates and discussion	Cable Hogue Marketplace Implementation Analyst and Federal Liaison
1:55 – 2:15 pm	Window shopping tool analysis and future considerations	Updates and discussion	Katie Button Marketplace Plan Management Analyst
2:15 – 2:35 pm	State-based marketplace transition analysis	Updates	Victor Garcia Marketplace Operations Development Specialist
2:35 – 2:45 pm	Public comment		Dan Field Committee Chair
2:45 – 3:00 pm	Closing remarks		Dan Field Committee Chair
Adjourn			



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

Thursday, November 21, 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, Cindy Condon, Dan Field (Chair), Joe Enlet, Jim Houser, Ken Provencher, Lou Savage (ex-officio), Numi Griffith, Sandy Sampson, and Shanon Saldivar (Vice-chair).

Committee members via phone: Jenn Welander, Jeremy Vandehey (ex-officio), and Sean McNulty.

Members excused: Shonna Butler and Stephanie Castano.

Other presenters: Jackie Yerby, Stephanie Kennan (by phone)

Marketplace staff: Chiqui Flowers, Administrator; Cable Hogue, Implementation Analyst and Federal Liaison; Victor Garcia, Operations Development Specialist; Nina Remple, COFA Program Manager; and Dawn Shaw, Division Support Coordinator

Agenda item and time stamp*	Discussion
Welcome and introductions, committee housekeeping 0:0:00*	<p>Welcomed the new interim Director of DCBS, Lou Savage. He is filling in for Cameron Smith, who stepped down to run for Secretary of State. There is a recruitment out for a permanent director. Lou has been a legislative director during the Governor Kulongoski era, former Insurance Commissioner, and most recently was the Administrator for the Workers' Compensation Division. Is familiar with the Stage Gate process to get technology moved forward.</p> <p>The committee agreed to postpone approving the meeting minutes from October 21 due to additional corrections that need to be made.</p>
SB 889 Committee 0:12:15	<p>Jeremy Vandehey presented an update of SB 889 Committee and the planning.</p> <ul style="list-style-type: none">As a reminder, the legislature passed SB 889 which will create the fourth-in-the-nation Statewide Health Care Cost Growth Target. It is a per capita target for health care costs, including those incurred through Medicaid, commercial insurance, and Medicare. This will broaden current targets and apply it statewide, creating a budget target for health care costs. Health care costs are currently high and growing. This process will allow the state to collect data and see where the costs are growing so we can have an idea on what needs to be done to contain costs.The state has done a good job in meeting targets with state health programs like Medicaid and public employee programs. The commercial market is the area where there are some challenges. The money could be going to wages and retirement instead of health care that is growing at an unsustainable rate. The average rate of growth is about 6.5% and out-of-pocket costs have been growing faster.Overall program will operate similar to the Massachusetts program, but will be adjusted to best meet our goals. Set the goal for next year, collect the data from insurers, then analyze to see what the cost-drivers are. Will be able to sit down

with organizations that are above the cost target, understand what the common cost drivers are and the reasons for them, and recommend corrective action/s to drive down the costs. There will be an annual report to the legislature.

- Within the last month, the Governor has appointed an 18-person group, which several MAC members are a part of (Kraig Anderson, Ken Provencher, Shannon Saldivar, and Jenn Welander) and Andrew Stolfi from the Division of Financial Regulation. Have had an initial meeting to chart the course on how the group will operate. The Governor has given the group five things to keep in mind as the work is progressing, among those are:
 - The target they pick should be an aggressive constraint on health care costs to get them in line with economic growth.
 - Increase transparency and leverage the state's systems like the All Payer All Claims database to create a framework as to what is driving costs.
 - Provide data to OHA, DCBS, and other state agencies to have them understand what the cost drivers are.
 - Even though the focus is on costs, don't sacrifice quality of health care.
 - Submit a bill in the 2021 legislative session that provides robust enforcement and accountability tools if an organization is not meeting the target.
- Set the agenda for the next meeting and scheduled out meetings until next September. The group has a year to get their work done and submit their final recommendations to the Policy Board for approval by August and to the legislature in September. There is a website set up if you want to monitor the progress.
- Next month, they will be defining what is total health care spending. In January and February, committee will look into potential economic indicators to use as the basis of the target. From there, they will move into quality and transparency.
- What success looks like at the end of this would be containing costs and reducing cost growth and a standardized and transparent way at looking at cost growth.
- Massachusetts has the second highest health care costs, with Alaska being the highest. Prior to them implementing the program, they had the highest year-over year growth, some years as high as 10%. After program implementation on the commercial side, the rates fell well below the national average. They haven't hit the target every year, but on average, they are now below the national growth. The challenges that they experience are not much different from ours. They are seven years into this now.

Governor's health policy priorities

0:47:33

Jackie Yerby provided an update and discussed Governor Kate Brown's health policy priorities.

- Jackie has been the Deputy Health Advisor for Governor Brown since March. Prior to that, she was the policy director for the Urban League of Portland. Spent 20 years in the Blue Cross Blue Shield system. Has a masters in public policy with a concentration in health policy from the Kennedy School of Government.
- About a year ago, the Governor's Office issued a white paper with her health care priorities, which are still intact.
 - SB 770 is something that we are interested in seeing what they come up with in regards to universal coverage.
 - We were able to get a six-year financing plan for the Oregon Health Plan.
 - Behavioral Health integration has created a council and is working on increasing the range and making sure people are getting the right level of

- care in the right locations. Focusing on people with chronic mental illness. We want to make sure that we build a budget for the next biennium.
- Social determinants of health, CCOs have spending requirements and moving towards a value-based payment system and financial stability.
- Public health modernization, looking for a better term. Concerning vaping-related illnesses, the flavor ban was stayed. When they were trying to work with the health departments throughout the state, they realized that we don't have the kind of public system to respond to issues like the vaping crisis or other situations that may come along.
- Short session is coming up and the government has five bills, climate is the top priority and are trying to get those across the finish line.
- About the Marketplace recommendation to moving towards a state-based system, the Governor realizes the limitations of HealthCare.gov and supports moving towards a state-based system and one of the limitations is timing. There are competing IT priorities and getting the state resources to make this happen. Through SB 770, workgroup will be recommending a path towards universal health care. It would help facilitate and put us in a better position than we are in now. There is some instability with the ACA and waiting to see what happens with that.

State-based marketplace model transition

1:21:46

Victor Garcia provided an update and facilitated discussion on Oregon transitioning from a state-based marketplace using the federal platform (SBM-FP) model to a state-based model.

- Reviewed the handout – Joint OSCIO/LFO Stage Gate Review Process. The added dates in green assume a a planned Open Enrollment (OE) 2023 timeline. We currently are at the “we are here” marker, before any of the project oversight timeline starts.
 - This process is designed so that any agency that is considering an IT project at or above \$1 million over five years has done their homework. Not all projects go through this process, it depends on the complexity.
 - We are currently in the stage where we are developing the initial required documents. The Office of the State CIO (OSCIO) is looking for a high-level business case, fiscal plan, and overall alignment with your agency's mission and how you plan to pay for it.
 - We are in the process of getting those documents together now and have done some of the initial work already. We will submit when the timing is appropriate.
 - The green circles indicate stages that happen a little later than when we would need them to happen if Oregon wanted something in place for OE 2023.
 - There is a collaboration between the OSCIO and the agency. Every agency has a portfolio manager from the OSCIO that oversees the activity. There may be a recommendation to contract out for a project manager.
 - The OSCIO project approval process can be lengthy. Some things like process mapping can be done now.
 - There may be more favorable consideration of funding mechanisms because this wouldn't be funded by the General Fund, but by premium assessments.
 - Initially, we will have to work with our current budget if we need to hire consultants.
-

Federal health policy movement

1:49:06

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

- Texas v. Azar – we are expecting a decision from the federal appeals court any day now. If the ruling goes against the administration, which would be dismantling the law, they could ask the full court to provide an opinion. Regardless it will go to the Supreme Court and likely not be heard until next fall.
- Not a lot has been going on in Congress regarding the ACA. Early this year, a number of drug provisions were added to bills to fix the ACA. They would pass in the House, but would die in the Senate.
- The Senate did pass the continuing resolution, the previous continuing resolution expired, to fund the government. The president agreed to the one-month extension that expires on December 20. The Senators were scheduled to go on their Christmas break on December 16 were asked to remain in Washington D.C. Last year it wasn't a complete government shutdown, and it looks like it will go down to the wire on December 20 before there is a determination.
- Prescription drug update – there was policy bill, HR 3, which is about drug negotiations and it has become the centerpiece on what the House would like to have as a response about drug prices. Initial plan was to have HR 3 voted on by the end of October. The CBO (Congressional Budget Office) is still working on the score. The score should be released any day now. The bill is supposed to save a lot of money. There have been some meetings on how to use the money from the savings, one would be shoring up the ACA and putting money into Medicare for dental and vision. There isn't an agreement on what to use the savings for, but it would not be going towards the deficit. Some concern has been raised due to the penalties to drug companies who do not participate or complete their negotiations. For each drug every year, they could face up to 95% penalty on the revenue brought in on the drug. Drug companies are not happy about it. There doesn't seem to be much support for this bill in the Senate. The House has been passing pieces of what would be a larger compromise bill. Ultimately, it is believed that what will become the compromise will be the Senate Finance Committee bill. It doesn't have drug pricing in it but would try to address other issues like putting more generics on the market and rebates.
- Surprise billing – this issue everyone thought would be done by now has fallen further and further into the background. There is an inability to get the stakeholder groups together on what the solution would look like. There is a difference between arbitration and benchmarking prices. There does not appear to be a compromise.
- There are some watchdog groups keeping an eye on Open Enrollment. It appears that enrollment is down by about 250,000 in comparison for the last two years, in spite of more options and lower premiums. The decrease has some people worried. There seems to be no timeline on addressing the Health Insurance Tax.
- Things seem to be slowing down, especially with the impeachment hearings.
- Joe Enlet requested an update for HB 4821/SB 2218 – Covering our FAS Allies Act. It seeks to restore Medicaid eligibility to COFA Islanders taken away by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act. Stephanie did not have an update but was going to follow up with Chiqui via email.

2020 Open Enrollment

Chiqui Flowers presented updates for the Oregon Health Insurance Marketplace 2020 Open Enrollment (OE).

2:09:01

- It is day 21 of Open Enrollment, the seventh Open Enrollment as a state-based marketplace, and the fifth being on the federal platform.
- As of November 20, we are at 27,571 for overall plan selections. This is down 17% from the same time last year, with one day less in the weekly count. The 2019 OE baseline is 148,180. Keep in mind it is only week three. There are still some auto-enrollments still pending, and they are up 3% from last year's week three. We forecast, with no new enrollees, we should be at 85% of the 2019 OE baseline. It is trending down, will be more concerned after Thanksgiving, when most of the consumers should be enrolling.
- Partner Agents
 - We have 32 partner agents awarded for the plan year 2020. Enrollments through HealthCare.gov have been fairly smooth with the exception of the morning of day one when there was some lo in issues that were resolved before noon that day.
 - We have heard that the federal marketplace has been requesting documentation for almost all non-citizen applicants. According to our partner agents, this requirement was far less often in previous OEs. There has been issues with citizens' enrollments as well, there is not anything that should be holding up those reservations. The issue may be on the Social Security side, with problems accessing the system, if their system is down, there will be problems. Email Cable to see if there is a Social Security outage. The Marketplace call center can help facilitate a call with consumers to help resolve issues.
 - Web broker usage is up amongst partners and going well with the exception of intermittent issues with Health Sherpa, which is an online portal to assist with finding affordable ACA plans.
- Community Partner (CP) Grantees
 - We have contracts with eight organizations to provide outreach and enrollment assistance to consumers from August 2019 through July 2020.
 - Each of the grantees had a first quarter check in with Rob Smith, our CP liaison, and they reported they are making progress towards OE goals: hiring staff, training all assisters, holding enrollment fairs, organizing health insurance education sessions, and scheduling enrollment assistance appointments with consumers.
 - We took over the CP training from the federal marketplace last year. We have two tiers: basic (one-and-a-half hour) and advanced (four hours). It is required for anyone assisting consumers with HealthCare.gov enrollment that they take both basic and advanced. Advanced requires attendees to complete and pass a 35-question quiz for certification.
 - Since July 2019, 1,019 CP assisters have taken at least the basic training. 76 trainings have been provided by the Marketplace team, some of them in Spanish. As of 11/18/19, 474 have passed the certification exam.
- Marketing Tactics
 - Video ads on TV, streaming video, and social media. Audio ads on streaming services, in English, Spanish, and Russian stations. Digital ads on websites and search engines. Print ads in English, Spanish, and Russian. Outdoor advertising on billboards in English.

- Video, audio, and graphical ads from actual consumers with themes of “The Basics”, “Testimonials”, and “People Like Me”. We have received good feedback from an ad running on Hulu.
- Performing spotlight on search ads – impressions and clicks are up significantly from last year. Search engine ads are the top driver to OregonHealthCare.gov. Among search ads, people ages 25 to 34 years are the top clickers and are clicking ads 86 percent more than last year.
- In the first ten days of OE: traffic to OregonHealthCare.gov is up slightly, traffic from known male web users is up slightly, but down so far on the 25-to-34 age group.
- There was a solid local media coverage of the OE launch on OPB radio, KATU, Oregonian, Portland Tribune, and My Oregon News.
- Window Shopping site
 - We have had positive feedback so far.
 - Released on October 18, 2019 and from then to November 14, the total number of users was 17,006. Consumers are spending an average of seven minutes on the site. About 20% of users come back and use the site again. Majority of the users are in the Portland metro area, Eugene, and Bend.
 - Most users access the site through OregonHealthCare.gov. About 4,000 users used the direct URL oregonhealthcare.gov/windowshop, sent out via e-mail blast. People receiving email blasts signed up through GovDelivery and we get a list from CMS every year with current enrollees. Smaller numbers used the tool after seeing it published online in local news articles.
 - The majority of users enter their household information to see which subsidies they may qualify for. Many of them then continue on to view and compare plans.

COFA medical and dental

2:31:41

Nina Remple and Cable Hogue provided an update on the COFA program both medical and dental.

- As of 11/12/19, we have 462 COFA citizens applying for premium assistance. As of 11/21/19, the number has increased by around 100. 263 from the Federated States of Micronesia, 173 from Republic of the Marshall Islands, and 26 from the Republic of Palau. We will start tracking the Micronesians to see which islands they are coming from.
 - The 2017 OE was November 1, 2016 to January 31, 2017. In 2018, the OE changed to November 1 to December 15. 2017-2018 there were 202 renewals, 2018-2019 there were 331, and continuous enrollment from 2017 to 2019 is 129.
 - We have had six enrollment events, with two remaining.
 - Brief dental update
 - HB 2706 charged DCBS with procuring a study to assess the COFA population and geographic hot spots where they live and a dental needs study. We did an RFP and had one respondent who proposed a price that was well above the available budget given to us by the legislature. We had to narrow down the scope a little bit. It was determined that we can get a good representation from the COFA medical enrollees. We have a dental needs contractor, MGT Contracting of America, LLC, who is drawing from other state populations, Medicaid, other high-population COFA states like Hawaii, taking a look of at the Washington, Arkansas, and Oklahoma. One of the consultants came out to Oregon to attend a ~~few~~ COFA enrollment event and a few house visits with a COFA partner agent. With permission, the consultant was able to ask people face-to-face what their dental needs are.
-

- On December 15, they will be issuing a draft report of what the likely needs of the population are. We will review and ask for any clarifications, with the final report to be completed by the end of January.
- Anthony Behrens issued an RFI to the dental carrier organizations through the state Medicaid program. We gave them information we have collected in the past gathered through assisters.

Closing

Next meeting will be Thursday, January 23, 2020.

At the last meeting, we extended the term limit of committee members from two to three consecutive two-year terms. Most terms end at the end of January 2020. We are working with the Governor's office to stagger the terms. Over the next couple of weeks we will be sending out information on how to extend your terms. Jackie Yerby will work to help figure out the staggering.

We will be sending out a final copy of the October meeting for final approvals. Email Chiqui for any additional follow up items.

*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, November 21.

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

OFFICE OF THE SECRETARY OF STATE

BEV CLARNO
SECRETARY OF STATE

A. RICHARD VIAL
DEPUTY SECRETARY OF STATE



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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

HMP 2-2019

CHAPTER 945
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
HEALTH INSURANCE MARKETPLACE

FILED

09/20/2019 2:46 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amendment to Insurer Administrative Charge Calculation and Rebate Credit Schedule

EFFECTIVE DATE: 09/20/2019 THROUGH 03/17/2020

AGENCY APPROVED DATE: 09/20/2019

CONTACT: Victor Garcia 350 Winter St NE
971-283-1878 Salem, OR 97301
victor.a.garcia@oregon.gov

Filed By:
Victor Garcia
Rules Coordinator

NEED FOR THE RULE(S):

The administrative charge calculation in the current rules does not accurately reflect the amount to be refunded to carriers. The amendment ensures that the calculation takes into account the entire ending fund balance and shortens the time to credit the rebate in full from 24 months to 12 months.

JUSTIFICATION OF TEMPORARY FILING:

- Failure to immediately amend the rule will result in miscalculation of the amount that the Marketplace must refund to carriers.
- Consumers who rely on services, education, and outreach provided by the Marketplace would suffer as result because the amount refunded would negatively impact the Marketplace's budget and could impact services.
- OAR 945-030-0020 requires the Marketplace to calculate the refund by September 30, 2019. There is not time to conduct a regular rulemaking prior to September 30, 2019 to fix the calculation error. Filing the amendment via temporary rule will allow the Marketplace to correct the calculation error prior to the September 30, 2019 deadline.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

ORS 741.002, 741.003, and 741.105 can be found here: https://www.oregonlegislature.gov/bills_laws/ors/ors741.html

RULES:

945-001-0002, 945-030-0020

AMEND: 945-001-0002

RULE SUMMARY: 945 Definitions, the amendment adds the definition for "biennium" to OAR Chapter 945

CHANGES TO RULE:

945-001-0002

Definitions ¶

The following definitions govern the meaning of terms used in administrative rules in this chapter, except where the context otherwise requires:¶¶

- (1) "Advance payments of the premium tax credit" means payment of the federal health insurance premium tax credit on an advance basis to an eligible individual enrolled in a QHP through the Marketplace.¶¶
- (2) "Affordable Care Act" or "ACA" has the meaning given in 45 CFR 155.20.¶¶
- (3) "American Indian", for purposes of eligibility for tax credits and cost sharing benefits, means an enrolled member of a federally recognized tribe.¶¶
- (4) "Applicant" has the meaning given in 45 CFR 155.20.¶¶
- (5) "Automatically enroll" means the process of enrolling a qualified individual into a new qualified health plan when, at renewal:¶¶
 - (a) The qualified individual's qualified health plan issuer no longer offers qualified health plans through the health insurance exchange; or¶¶
 - (b) There are no qualified health plans offered through the health insurance exchange under the individual's previous qualified health plan product.¶¶
- (6) "Benefit year" has the meaning given in 45 CFR 155.20.¶¶
- (7) "Biennium" means a two-year period beginning on July 1 of an odd year and ending on June 30 of the following odd year.¶¶
- (8) "Catastrophic plan" means a health plan described in §1302(e) of the Affordable Care Act.¶¶
- (89) "CHIP" or "Children's Health Insurance Program" means the portion of the Oregon Health Plan established by Title XXI of the Social Security Act and administered by the Oregon Health Authority.¶¶
- (910) "Cost sharing" has the meaning given in 45 CFR 155.20.¶¶
- (101) "Cost sharing reductions" has the meaning given in 45 CFR 155.20.¶¶
- (112) "DCBS" means the Oregon Department of Consumer and Business Services.¶¶
- (123) "Effectuation" means the activation of QHP or SADP coverage through enrollment and payment of the first month's premium.¶¶
- (134) "Employee" has the meaning given in section 2791 of the Public Health Services Act.¶¶
- (145) "Employer" has the meaning given in 45 CFR 155.20.¶¶
- (156) "Enrollee" has the meaning given in 45 CFR 155.20.¶¶
- (167) "Essential health benefits" has the meaning given in OAR 836-053-0008.¶¶
- (178) "Federal poverty level" or "FPL" has the meaning given in 45 CFR 155.300.¶¶
- (189) "Full-time employee":¶¶
 - (a) For plan years beginning prior to January 1, 2016, means an "eligible employee" as defined in ORS 743.730.¶¶
 - (b) For plan years beginning on or after January 1, 2016, full-time employee has the meaning given in section 4980H(c)(4) of the Internal Revenue Code.¶¶
- (1920) "Health benefit plan" has the meaning given in ORS 741.300.¶¶
- (201) "Health care service contractor" has the meaning given in ORS 741.300.¶¶
- (212) "Health insurance" has the meaning given in ORS 741.300.¶¶
- (223) "Health insurance exchange" or "exchange" has the meaning given in ORS 741.300.¶¶
- (234) "Health plan" has the meaning given in ORS 741.300.¶¶
- (245) "Household" has the meaning given in 42 CFR 435.603.¶¶
- (256) "Household income" has the meaning given in 26 CFR 1.36B and 42 CFR 435.603.¶¶
- (267) "Individual market" has the meaning given the term in section 1304(a)(2) of the ACA.¶¶
- (278) "Insurer" has the meaning given in ORS 741.300.¶¶
- (289) "Insurance affordability program" has the meaning given in 42 CFR 435.4.¶¶
- (2930) "Lawfully present" has the meaning given in 45 CFR 152.2.¶¶
- (301) "MAGI-based Medicaid and CHIP" means Medicaid and CHIP programs for which eligibility is based on modified adjusted gross income, and not primarily on age or disability.¶¶
- (312) "Medicaid" means medical assistance programs established by Title XIX of the Social Security Act and

administered in Oregon by the Oregon Health Authority.¶¶

(323) "Minimum contribution requirement in the case of a medical plan" means a small employer must contribute at least 50 percent of the employee-only premium. If a small employer elects to offer more than one medical plan to employees through SHOP, the minimum contribution requirement will be determined based on a reference plan selected by the employer. In the case of a dental plan, the employer must contribute at least \$20 per enrolling employee.¶¶

(334) "Minimum essential coverage" has the meaning given in section 5000(A)(f) of the Internal Revenue Code.¶¶

(345) "Minimum participation requirement", in the case of a medical plan, means that at least 75 percent of the employees offered SHOP medical coverage must enroll. In the case of a dental plan, at least 50 percent of the employees offered SHOP dental coverage must enroll.¶¶

(356) "Modified adjusted gross income" or "MAGI" has the meaning given in 26 CFR 1.36B-1(e)(2).¶¶

(367) "Oregon Health Insurance Marketplace" or "Marketplace" means the health insurance exchange operated within DCBS for the State of Oregon pursuant to ORS chapter 741.¶¶

(378) "Oregon Insurance Division" means the Insurance Division of DCBS.¶¶

(389) "Pediatric dental benefits" has the meaning given in OAR 836-053-0008.¶¶

(3940) "Plan year" has the meaning given in 45 CFR 155.20.¶¶

(401) "Qualified employer" means an employer who meets the requirements to participate in the Small Business Health Options Program.¶¶

(412) "Qualified health plan" or "QHP" has the meaning given in ORS 741.300.¶¶

(423) "Qualified Individual" has the meaning given in 45 CFR 155.20.¶¶

(434) "Resident" means an individual who lives in Oregon with or without a fixed address, or intends to live in Oregon, including an individual who enters Oregon with a job commitment or looking for work. There is no minimum amount of time an individual must live in Oregon to be a resident. An individual continues to be a resident of Oregon during a temporary period of absence if he or she intends to return when the purpose of the absence is completed. An individual is not a resident if the individual is in Oregon solely for a vacation or other leisure activity.¶¶

(445) "Silver-level qualified health plan" means a QHP that provides a level of coverage that is designed to on average provide benefits that are actuarially equivalent to 70 percent of the full actuarial benefits provided under the plan.¶¶

(456) "Small Business Health Options Program" or "SHOP" has the meaning given in ORS 741.300.¶¶

(467) "Small employer" has the meaning given in ORS 743.730.¶¶

(478) "Standalone dental plan" or "SADP" means a health plan that provides pediatric dental benefits and that is not offered in conjunction with a QHP.¶¶

(489) "State program" has the meaning given in ORS 741.300.¶¶

(4950) "Tax filer" has the meaning given in 45 CFR 155.300.

Statutory/Other Authority: ORS 741.002

Statutes/Other Implemented: ORS 741.500

AMEND: 945-030-0020

RULE SUMMARY: The amendment makes changes to when an administrative charge refund is calculated, and the length of time over which the refund is disbursed (as a reduction of the ongoing Marketplace administrative charge), from 24 months to 12 months.

CHANGES TO RULE:

945-030-0020

Establishment of Administrative Charge Paid by Insurers ¶¶

(1) After consulting with the advisory committee created by Section 13 of 2015 Senate Bill 1, the Marketplace will annually provide a report on administrative charges to the Director of the Department of Consumer and Business Services.¶¶

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

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

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

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

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

(4) The department will hold a public hearing on a proposed administrative charge.¶¶

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

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

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

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

(9) By the 30th day of September of every odd year, the department shall:¶¶

(a) ~~Calculate~~Determine the maximum amount of funds that the department may hold under ORS 741.105(3)(b) by calculating:¶¶

(A) ~~The Marketplace's fund balance as of the 30th day of the immediately preceding June minus:~~¶¶

~~(B) One-fourth of the Marketplace's budgeted operating expenses for the two-year period beginning end of the biennium immediately before the date by which the calculation is required to be made minus:~~¶¶

(B) One-fourth of the Marketplace's budgeted operating expenses for the biennium in which the calculation must be made as required by paragraph (9).¶¶

(b) Credit each individual carrier participating in the first day of the immediately preceding Marketplace an amount equal to the pro-rata share of any positive difference obtained from the calculation described in July and ending on the 30th day of June of the following odd year;¶¶

(b) paragraph (9)(a) of this rule based on the total assessments the carrier reported to the department during the two-year period described in paragraph (9)(a)(A) of this rule plus the pro-rata share of the total assessments reported during the two-year period described in paragraph (9)(a)(A) of this rule by carriers no longer selling qualified health plans through the Marketplace.¶¶

(10) Examples:¶¶

(Aa) Example 1: If the Marketplace's fund balance is \$1 million as of ~~June 30, 2017~~the end of the 2017-2019 biennium and its operating budget is \$4 million for ~~July 1, 2017 through June 30, 2019~~the 2019-2021 biennium, the department would retain \$1 million and credit carriers \$0.00 because there is no excess fund balance - \$1 million minus (\$4 million divided by 4) is zero;¶¶

~~(Bb)~~ Example 2: If the Marketplace's fund balance is \$1 million as of ~~June 30, 2017~~the end of the 2017-2019 biennium and its operating budget is \$2.4 million for ~~July 1, 2017 through June, 2019~~the 2019-2021 biennium, the department would retain an excess fund balance of \$600,000 and credit a total of \$400,000 to carriers - \$1 million minus (\$2.4 million divided by 4) equals \$400,000; and¶

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

~~(A) Example 13: If the difference in the calculation described in paragraph (9)(b) of this rule is less than or equal to zero on June 30, 2017, there is no excess fund balance and the department would not credit any individual carrier because the fund balance is either zero or negative.¶~~

~~(Bd)~~ Example 24: If, after performing the calculation described in paragraph (9)(b) of this rule, the excess fund balance is \$1.28 million on June 30, 2017, and Carrier A ~~paireported~~ 10% of the total assessments the Marketplace received between July 1, 2015 and June 30, 2017reported during the two-year time period described in paragraph (9)(a)(A), the department must credit Carrier A a total of \$1280,000 - \$1.28 million multiplied by .10 equals \$1280,000.¶

~~(101)~~ Except as provided in paragraph 112 of this rule, the department shall apply the credit described in paragraph (9)(e) of this rule by reducing each monthly charge assessed during the period described in paragraph (9)(a)(B) by one-twenty-fourth of the credit~~eleventh of the credit rounded to the nearest whole dollar beginning the first day of January following the date specified in paragraph (9) of this rule for 11 consecutive months. Any remaining credit rounded to the nearest whole cent shall be credited in the twelfth month.~~ For example, if, after performing the calculation described in paragraph (9)(b) of this rule, the excess fund balance is \$1.2 million on June 30, 2017, and Carrier A ~~paireported~~ 10% of the total assessments received by the Marketplace between July 1, 2015 and June 30, 2017during the time period specified in paragraph (9)(a) of this rule, the department must credit Carrier A \$5,00010,909 per month in each month the carrier participates in the Marketplace between July 2017 through June 2019 - (\$1.2 million multiplied by beginning the first of January following the date specified in paragraph (9) of this rule for 11 consecutive months or until Carrier A no longer provides coverage through the Marketplace. In the twelfth month following the date specified in paragraph (9) of this rule, the department must credit Carrier A \$1.09. (The product of \$1.2 million and the quotient of .10} divided by 2411 equals \$5,000.¶ (1110,909.090909091 rounded to the nearest dollar equals \$10,909. The product of .090909091 and 12 equals 1.090909092 rounded to the nearest cent equals \$1.09.)¶

~~(12) Notwithstanding paragraphs (9)(b) and (11) of this rule:¶~~

~~(a) If the director determines that application of the credit as described in paragraph (101) of this rule would jeopardize a Marketplace carrier's financial solvency, the department may use any reasonable method to credit the carrier the amount due under paragraph (9)(e) of this rule(b) of this rule; and¶~~

~~(b) A carrier is not entitled to credit or payment for assessments:¶~~

~~(A) If the assessments were not paid to the Marketplace; or¶~~

~~(B) If the carrier does not offer coverage through the Marketplace.~~

Statutory/Other Authority: ORS 741.002, 741.005

Statutes/Other Implemented: ORS 741.105

Summary of Rulemaking – Amendments to OAR 945-001-0002 and OAR 945-030-0020

The purpose of this rulemaking is to make final the amendments to OAR 945-001-0002 and OAR 945-030-0020 that were made pursuant to temporary rules issued in September 2019. The amendments made in 2019:

- Add a definition of biennium (2-year period beginning July 1 of every odd year and ending June 30th of the following odd year).
- Reduce the rebate crediting period from 24 months to 12 months.
- Specify that rebates will be credited beginning the January following the end of the biennium.
- Specify that rebate credits will be paid in 12 monthly installments, the first 11 of which are to be credited in equal dollar amounts. The 12th credit is whatever is left over.
- Clarify that a carrier is (1) entitled to a pro rata share of rebates that would otherwise be owed to carriers no longer participating in the marketplace and (2) not entitled to a rebate if it (a) didn't pay assessments or (b) is not a participant in the Marketplace.

Questions for Advisory Committee

1. Economic impact on state agencies, units of local government, and the public (ORS 183.335(2)(b)(E))?
2. Cost of compliance effect on small business (ORS 183.336)?
3. Estimate of the number of small business and types of businesses and industries with small businesses subject to the rule?

2020 Open Enrollment Data



2020 Open Enrollment Data



- Overall Plan Selections: 145,264 down 2% from last year (148,180)
- Auto Re-enrollments: Up 10% from last year
- New Consumers: Down 8% compared to last year (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.
- Returning Consumers with an active plan selection: Down 3% from last year

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2020 Open Enrollment Data



- 2.7% decrease in share of plan selections with APTC
- 3.1% decrease in share of plan selections with CSR (Cost Sharing Reductions)
- 3.6% increase in share of Bronze Plan selections
- 2.3% increase in share of Gold Plan selections
- 5.9% decrease in share of Silver Plan selections

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Marketplace Window Shopping Update

Katie Button
Plan Management Analyst



Marketplace Window Shopping Site



- Window Shopping was released on October 18, 2019
- From October 18, 2019 to December 17, 2019, the total number of unique users was 35,337
- The majority of users were in the Portland area, followed by Eugene, and Bend

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Marketplace Window Shopping Site, Cont.



- Consumers spent an average of seven minutes on the site
- Many users entered their household information and browsed plans

Plan Tier	Unique Views	Total Views
Catastrophic	708	977
Bronze	26,033	41,040
Silver	17,620	29,047
Gold	16,448	24,512
All plans	60,010	95,576

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Marketplace Window Shopping Site, Cont.

- Implementation and maintenance of the site was very easy
- No major issues after site was released
- Feedback from users was positive
- Possible upgrades for 2021 include provider search and formulary search

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SBM Transition Analysis Update

Victor Garcia
Operations Development Specialist



Progress update: Other transitioning states



Nevada

- First OE transitioning to full SBM for 2020 was successful
- Local media appeared to be supportive or neutral through OE and after

New Mexico

- Selected vendor in 2019
- Still SBM-FP for 2020 and 2021, November 2021 launch target for OE 2022

Pennsylvania

- RFP asked for single submission for both technology and consumer support
- Selected a vendor, announced in Dec. 2019
- Nov. 2020 launch target for OE 2021

Progress update: Other transitioning states



New Jersey

- Change from FFM to SBM-FP for 2020
- Announced vendor selections this month
- Anticipated launch is fall of 2020 for OE 2021
- Separate technology and CAC vendors

Virginia

- Bills introduced in 2020 session for full SBM switch
- Approvals and timelines depend on session outcomes

Maine

- Transitioning to SBM-FP in 2020 for OE 2021, bill introduced in 2020 state legislative session (LD2007)
- No specific public plans for transition to full SBE yet

Enrollment comparisons



State	OE 2019	OE 2020	% change
Nevada	83,449	77,410 ¹	- 7.2%
New Jersey	255,246	246,426	- 12.6%
New Mexico	45,001	42,714	- 3.5%
Pennsylvania	365,888	331,825	- 5.1%
Virginia	328,020	269,474 ²	- 2%
Maine	70,987	62,031 ²	- 9.3%
Oregon	148,180	145,264	- 17.8%

¹ First OE as full SBM

² Some enrollment drop due to 2019 Medicaid expansion

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By the numbers: SBM tech and CAC contract simple comparisons by state



State	Annual M&O (combined tech & CAC, rounded to nearest 0.1 M)	Projected 1st year avg. enrollment (rounded to nearest K)	Annual M&O as PMPM (from rounded estimates)
Nevada ¹	\$5.2 M	75,000	\$5.78
New Jersey ¹	\$14.7 M	256,000 - 306,000 ³	\$4.00-\$4.79
Pennsylvania ¹	\$24.9 M	354,000	\$5.86
Oregon 2020 (FP) ²	\$20.8M	118,000	\$14.70

Key: M&O = Maintenance & operations; PMPM = per member per month;
CAC = consumer assistance center; FP = Federal Platform

1. Based on public contract information and estimates in released RFPs

2. Based on 2020 Marketplace Assessment Memo published Feb. 2019

3. No projections available: NJ RFP asked vendors to estimate cost based on a potential increase over 2019 enrollment of up to 20%, reflected in this range

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Analysis tasks in progress



Business Case

- Explanation, justification, options analysis
- Estimated costs and resources (contracts, new FTEs, etc.)
- Biggest challenge so far: concise summaries in plain language that accurately reflect the concepts

Budget estimates

- Modeling based on other state contracts and implementations
- Balancing FTE request – ideal vs. minimum
- Projections of multiple annual assessments years in advance

Homework

- Other state experiences – monitoring media, ongoing dialogs
- External resource availability – RWJF, other grant or information exchange opportunities
- Deconstructing and aggregating other state RFP requirements

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Dovetails with ongoing Marketplace work



Business Process Mapping

- Enhancing understanding of processes currently in place, and refining where necessary
- Identifying the need for documenting new ones
- Distillation for use in business case

Annual Assessment

- Unable to anticipate and build in project costs for 2021 without preliminary budget approval
- Any approved budget estimates must reconcile with offset plan year/fiscal year schedules and actuals going forward

2021 session prep

- The project and associated budget limitations themselves will need legislative approval as a POP
- POP will need information also needed for project business case and budget estimates

Closing



Questions and Discussion

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