



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

<b>Agenda item and time stamp*</b>	<b>Discussion</b>
<b>Welcome and introductions, committee housekeeping</b>  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.
<b>2019 Oregon legislative session recap</b>  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"><li>• COFA (Compact of Free Association) Dental, HB 2706 (passed)<ul style="list-style-type: none"><li>○ 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.</li></ul></li><li>• Health care cost review, SB 889 (passed)<ul style="list-style-type: none"><li>○ 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</li></ul></li></ul>

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).

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## 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 carriers<sup>1</sup>].
  - No indication that there are any network changes.
  - Press releases have gone out to inform the public. Kraig Anderson said that he felt that the content in the release was misleading and Cindy Condon seconded that sentiment. Cameron Smith acknowledged their 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.
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- 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](mailto: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.

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## 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 and 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 12/31/26
  - 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](http://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.
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- 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](http://healthcare.oregon.gov/marketplace/gov/Pages/him-committee.aspx)