**Market Reforms – Straw Plan and Issue Development**

In previous discussions, the Exchange Workgroup agreed that market reforms should include:

- An individual mandate;
- Guaranteed issue and guaranteed renewability;
- No pre-existing condition provision;
- Public subsidies for lower income Oregonians;
- Establishment of an essential services benefit package that is affordable, accessible, and consumer-valued; and
- Continued DCBS review of the medical loss ratios and administrative costs that make up insurance rates to ensure that rates, risk-based capital requirements and margins are sufficient, but not excessive.

In addition, in a reformed market carriers should compete based on the efficiency of their administration, on delivery system and network adequacy, and on other quality and service differences, rather than on a given plan's ability to get better risk. Based on these assumptions, the workgroup identified a number of issues that must be addressed for reforms to be successful. What follows is a "straw plan" for discussion and development by the workgroup.

1. **Risk Pool**
   a. One individual market pool.
   b. No pre-enrollment medical screening to determine rates or insurability or to create a separate high-risk pool. (Post-enrollment, insurer may be allowed to conduct health risk appraisal for management purposes.)

2. **Risk Management Options**
   a. Utilize risk adjustment mechanism to shift revenue between carriers based on the risk enrolled in each plan. Carriers that enroll high risk individuals receive more revenue; those with lower risk individuals receive less.
   b. Assess options for risk adjustment (prospective, retrospective), recognizing that it may be affected by existence of a voluntary Exchange.
   c. Recognizing that the state of the art in risk adjustment continues to evolve, a mechanism will be established to ensure the methodology established for risk adjustment is routinely reviewed and modified to ensure its ongoing value and efficacy. Application of the risk adjuster will be done by qualified and independent personnel and outside experts as needed.

3. **Financing Mechanism for High Risk Enrollees**
   a. The costs of the high risk and portability pools need to considered in the total risk pool but how those costs should be spread needs further study and a transition plan may need to be considered. Part of the challenge is capturing the annual $80 million currently collected to support OMIP.
   b. The current OMIP population may be initially held apart from the individual market, and transitioned into the general individual market over time. This may be a

financing separation or an actual separation of pools. Holding the OMIP enrollees apart would require additional premium assistance for current OMIP enrollees, so that their premiums are the same as those in the individual market (to limit OMIP enrollees' incentive to leave OMIP for the regular market).

c. Consider impact of introducing the current portability pool into the main individual market pool, as people in portability coverage are on average higher risk than the individual market.

**4. Benefit Design**

a. The Benefits Committee will define an essential services benefit that meets the individual mandate.

b. Carriers will file plans with DCBS to show that they meet or exceed the essential services benefit.

c. All products with benefits equal to or greater than essential services benefit must be offered on guaranteed issue basis.

d. Supplemental plans or disease-specific plans may or may not be subject to guaranteed issue. (Need more information on supplemental plans not considered health insurance under state code.)

e. Carriers will offer a plan equal to the essential services benefit defined by the Benefits Committee, and may offer plans that are "buy ups" from the basic benefit. To limit adverse selection to insurers based on plan offerings, pricing for higher benefit plans will be set to make these plans actuarially equivalent to the benchmark plan.

f. Once an essential services benefit is established, consider establishing (3-5) standardized benefit tiers. The first tier includes the essential services benefit defined in d, with additional tiers that are actuarially defined so that a benefit plan in level one is actuarially 60% of a plan in level three. Determining the appropriate number of tiers will depend on the richness of the essential services benefit.

g. The young adults (20-25) should not be considered differently, unless the cost of the basic benefit plan required and the initial enrollment of this population is low.

h. The Exchange could consider becoming more prescriptive with benefit plans if risk adjustment alone does not do enough to control risk selection.

**5. Plan Enrollment Period**

a. Individuals sign up and may change carriers or benefit plans only during annual open enrollment period (as is done in Medicare Advantage). Want to limit individual's attempts to game system by rapid switching between plans and in/out of insurance.

b. Assumes there is an effective way to get all or most Oregonians enrolled.

c. An individual enrolling from a period of non-coverage (choosing to not enroll when eligible) can only enroll during the next open enrollment period, and only into the essential services benefit plan until the next open enrollment.

d. An appeals and enrollment-period exceptions process will be developed to recognize situations in which an individual has a reasonable claim to enter the individual market or switch carriers outside of the open enrollment period. Similar to group market change of life event provisions.

e. Will develop rules regarding mandate responsibility for minors and others considered dependents.

f. Insurers are regulated to ensure their compliance with annual open enrollment period.

g. Work Group will work with Eligibility and Enrollment Committee regarding residency requirements for state premium participation.

**6. Transition Period Efforts**

a. Need work during transition period (moving from existing market to new), assuring fair and equitable movement with costs absorbed in a way that does not hurt the success of an individual pool.

**7. Group Market and Groups of One**

a. In absence of regulatory changes that align benefits and mandates in individual and group markets, do not change how groups of one are treated. As currently, groups of one will be eligible for the individual market and not group. Currently the individual market does not include the coverage mandates now required in the group market. If groups of one are allowed, sicker self-employed people will enter group market for the richer coverage, while healthier self-employed people will go into the individual market to get better rates.

b. In this discussion, "group of one" is a self-employed individual with no employees, not a employee group in which only one employee takes up employer-offered insurance.

c. Further discussion maybe required regarding differences between group and individual markets once the benefits are established.

**8. Rating**

a. The medical component of rates in the individual market will be based on each carrier's experience for all individual market enrollees, whether inside or outside the exchange.

b. Use statute or regulation to increase transparency in administrative and medical cost components of rates.

c. Start with a natural rate band based on actual experience of the overall individual market (between 5 or 6, estimated at 5.7 currently). Reevaluate after several years, retaining the possibility of lowering the rate band over time.

d. Continue to use age to determined rates. Do not use gender or health status.

e. Standardize use of age bands. All carriers (within and outside the exchange) will use consistent (5 year) age bands for rating for enrollees over age 19.

f. There will be one rate band for enrollees age 19 and under. This band must comply with the natural rate band spread

g. Keep small group market as it is regarding rating (rather than change it to match the individual market). Evaluate for impact over time; allow policy change if small groups are enrolled in exchange and/or disruption is found.

h. Due to the cost and difficulty of administering such rate adjustments, do not require carriers to utilize premium discounts for "healthy behaviors" (not smoking, enrollment in wellness programs). Allow the market to encourage healthy behaviors through means other than rating.

i. Monitor for selection issues, include in DCBS review.

j. Allow geography-based rating. Evaluate the impact of this course over time and make adjustments to policy if necessary.

**9. Limiting Disruption for Current Individual Market Enrollees**

a. The penalty for non-coverage must be high enough to encourage current enrollees to retain their coverage.

b. Many current enrollees will see some increase in rates.

c. Assess how to reduce impact on low income enrollees; do we allow these individuals into the subsidy program?

d. Utilize a phased in approach in order to transition currently insured into market with minimal disruption. Consider retaining current OMIP enrollees in program for some period in order to mediate the impact on individual market rates. Assumes additional subsidy of OMIP premiums so that enrollees do not pay higher than individual market rate.

e. Determine whether persons currently enrolled in employer sponsored plans who would be financially eligible for premium assistance will be allowed to access state premium contributions.

**10. Maintaining Carrier Participation**

a. Individual requirement enforcement rules must be strong.

b. Implement strong risk adjustment.

Note on Individual Mandate: Through discussion with the chair and vice-chair of the Eligibility and Enrollment committee, the Exchange Work Group has determined that operationalizing an individual mandate is part of the work of the Work Group. The issues involved in establishing an individual mandate are set out in a separate document, for review by a staff review panel and discussion by the Exchange Work Group.