DEPARTMENT OF CONSUMER & BUSINESS SERVICES

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Individual Health Insurance Premium Stabilization:
Transitional Oregon Reinsurance Program – HB 3458

Background: Starting in 2014, thousands of Oregonians will gain access to health insurance in the individual market through implementation of Affordable Care Act (ACA) market reforms. An analysis of the impact of these reforms estimates that Oregon individual premiums will rise by 38%, on average, to cover expanded benefits and the elimination of medical underwriting.[1] A key driver of this change is the entrance of individuals currently insured through the state and federal high risk pools and carrier portability plans, estimated to increase premiums by an average of 22%.

To stabilize premiums in the individual market, the ACA establishes a transitional federal reinsurance program. Under the program, all health insurance issuers and third-party administrators of self-funded groups pay a per capita amount in 2014 through 2016 to offset high claim costs for those who purchase coverage in the individual market. In 2014, the federal reinsurance assessment is $5.25 per enrollee per month, and the program will pay 80 percent of a member's annual claims between $60,000 and $250,000 (a maximum payment of $152,000 for any one member per year).

The federal program is estimated to reduce average premium growth in the individual market by up to 11.0% in 2014, and the benefit of this program will decrease in 2015 and 2016 as funding draws down. A state reinsurance program will further stabilize individual market premiums and spread large claims costs for high-risk enrollees to reduce uncertainty during implementation of market reforms.

Concept: HB 3458 establishes a transitional Oregon Reinsurance Program (ORP), to be administered by the repurposed Oregon Medical Insurance Pool (OMIP) Board. The Board will expand to include 12 members, two of whom will be representatives of the business community. Subject to statutory provisions, the Board will establish the ORP's annual assessment levels and reinsurance payment parameters. The Board will contract with a third-party administrator to carry out day-to-day operations, including the collection of assessments and delivery of payments.

Oregon Reinsurance Program Payment Structure

The Department of Consumer and Business Services Insurance Division conducted industry technical advisory group work sessions to explore the feasibility and structure of the ORP. Based on the group's feedback, the ORP provides additional reinsurance payments for claims arising from current high-risk populations (OMIP/FMIP, portability, and Children's Reinsurance risk pools). The ORP phases out over a three-year period and "wraps around" the federal payment parameters, thus maintaining federal funding for the national parameters while providing additional funding for claims costs not covered by the federal program.

In 2014, the ORP will pay the following for eligible members:

- 90 percent (i.e., 90% coinsurance rate) of a member's annual claims between $30,000 and $60,000;
- 10 percent of a member's annual claims between $60,000 and $250,000; and
- 90 percent of a member's annual claims between $250,000 and $300,000.

The ORP is estimated to reduce average premium growth in the individual market by up to 3.9% in 2014, for an estimated combined impact of the state and federal programs of 14.9%. The Board may uniformly reduce the state coinsurance rate if funding is not sufficient to pay all claims within the payment parameters.

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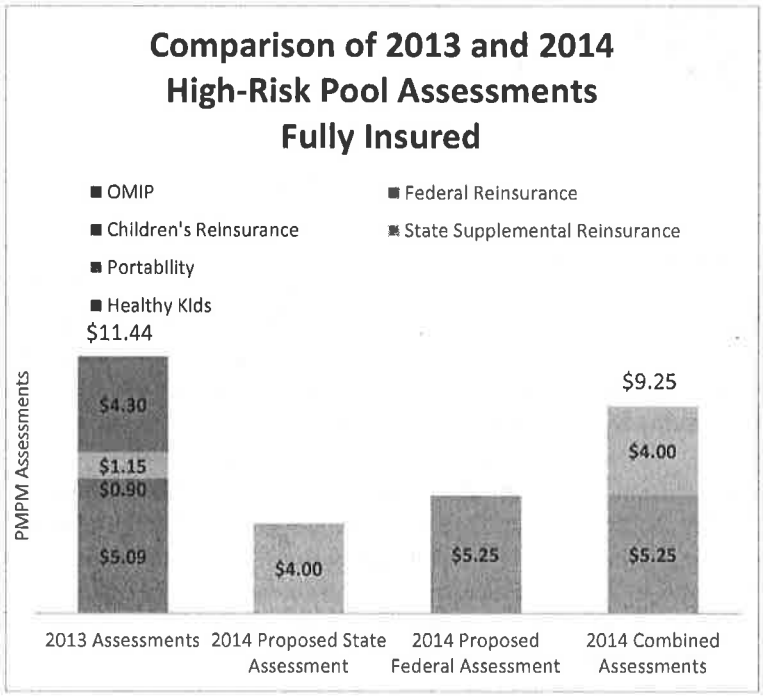
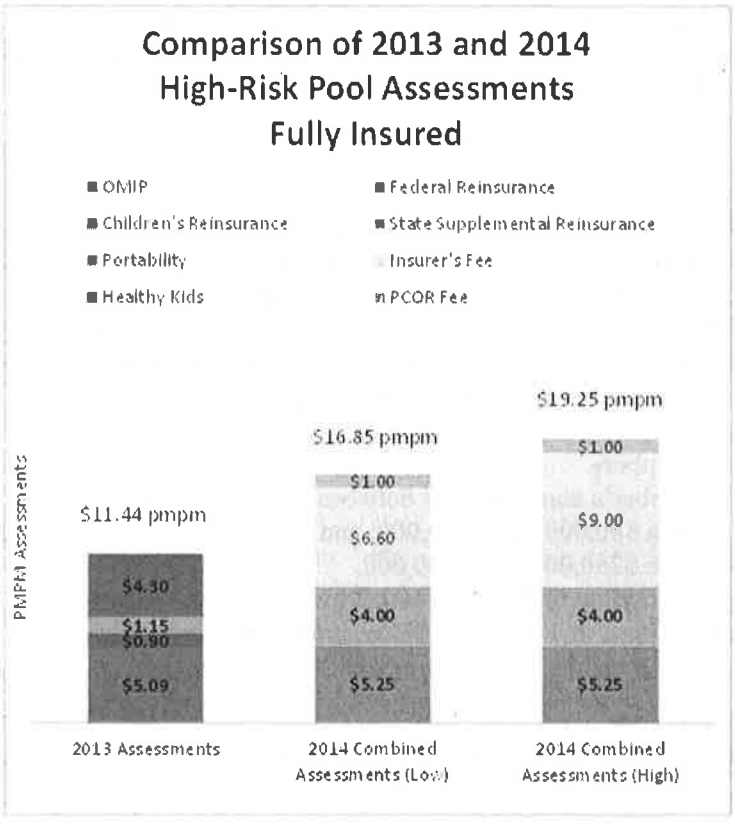
[1] Wakely Consulting Group (2012). *Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon.* http://insurance.oregon.gov/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf.

Oregon Reinsurance Program Assessment
The ORP will be funded by a per member per month (PMPM) assessment on individual, small group, and large group health insurance policies issued in Oregon, as well as self-insured employers who buy stop-loss coverage – the same population that currently pays the OMIP assessment. The 2014 assessment is $4.00 PMPM, subject to a statewide funding limit of $72 million. Assessment levels for 2015 and 2016 will be set by the Board, in accordance with PMPM and statewide funding limits included in HB 3458. The combination of state and federal reinsurance assessments totals $9.25 PMPM in 2014, which is slightly less than the $11.44 PMPM average assessment that exists in today's fully insured market to subsidize high risk populations. ***See chart at right.*** Self-insured assessment levels vary based on whether the entity purchases stop-loss insurance.



The ACA also introduces other fees in 2014 that increase the total amount of assessments and fees that insurers will pass through to their premiums. These new fees provide funding for Medicaid expansion ("Insurer's Fee") and research into comparative effectiveness of medical treatments ("PCOR Fee"), and when combined with state and federal reinsurance assessments, could range from $16.85 PMPM to $19.25 PMPM, depending on the insurer. ***See chart below.***



Timing
Insurers will be filing their 2014 individual and small group rates by April 30, 2013. The division has a short window to fully review a large number of filings and approve final rates that accurately reflect the impact of all rate stabilization programs, including the federal and state reinsurance programs. This final review must be complete by late June/early July.

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HB 2091

HB 2091 - Ends the Healthy Kids Connect program, a premium assistance program for children with family incomes between 201 and 300% Federal Poverty and transfers children into the Oregon Health Plan.

Background:
There are 379,762 children in OHP and 7,870 children in Healthy Kids Connect (HKC).

Children in OHP and HKC have comparable benefits, but there are premiums and co-pays for services on HKC.

Rationale for HB 2091:
Policy:

- Children get a better benefit in OHP that is more affordable for families.
- There will be more continuity of care for children as ¼ of children fell off of HKC because of non-payment of premiums (see below).
- It is likely that more families will cover their children if in OHP.
- Children in OHP will be in CCO's and cost growth held to 3.4%.
- It will be easier for families to enroll in OHP 1/1/14 through the insurance exchange web portal (see below).

Fiscal:

- There are savings of ~ $12 million GF for the 13-15 biennium
- It is expensive to administer a program for a small number of children

Technical:

- With ACA changes Jan 1, 2014, families between 200-300% will be split with parents in the insurance exchange and children in either OHP (with HB2091) or HKC (without HB2091).
- The single web portal to enroll families in coverage will allow for enrollment of children in OHP and parents in Cover Oregon (the exchange). It will be unable to enroll children in HKC as it was technically too difficult and too expensive to program the needed system changes within the time frame to get the exchange operational. As such, the state would still need to maintain a separate system for HKC and parents would need to use

two enrollment processes to get coverage – one for parental coverage and one for children.

Future Intent/Family Choice:

- With the advent of Cover Oregon, in the long run there is no good rationale to maintain HKC. It will most beneficial to allow families the choice of having their children covered in Cover Oregon with their parents or in OHP. We will be working to get the federal approval and make the needed enrollment system changes to allow families between 200-300% FPL to have the choice of using CHIP dollars to buy coverage for their children on the exchange or to remain in OHP. This will take at least a year.

Additional Background:

- HKC and Affordability – HKC Application and Enrollment Data give strong indicatation that many HKC families struggle to afford the program's premium cost-sharing, despite the significant state subsidy.
- A total of 20,292 children between 200-300% FPL applied and were found eligible for the program since it's inception, but current enrollment for this income group stands at 7,618 (the highest monthly enrollment to date)
- 3,478 (17%) of those who were found eligible never enrolled. Given that families applied for coverage and were found eligible, affordability is likely a key driver in their decision not to enroll the child. Families at this income level are extremely sensitive to cost sharing requirements.
- Of the 16,814 who did enroll in the program, 8,496 were terminated (That's 42% of all kids found eligible or 51% of all who enrolled).
- The #1 reason for termination was because family income decreased and the child was moved into OHP. This happened to 1,989 kids (40.5% of all terminations). That's compared to the 304 kids (6.2% of all terminations) who disenrolled because family income went above 300%.
- The #2 reason for termination was because of non-payment. 1,160 kids (24% of all terminations) were disenrolled because of non-payment of the family's share of the premium.
- Together, a family income dropping below 200% FPL or non-payment account for 3,149 children disenrolling from HKC (64.1% of all terminations or 32% of all children who enrolled).

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House Bill 2859A Background

House Bill 2859A contains technical changes that further clarify the separation of OHA from DHS and implement changes needed to align state statutes with changes in federal law. The bill accomplishes four main things:

1. Removes medical assistance from the definition of "public assistance" in ORS 411.010 (Section 32) and makes other technical and conforming changes to clarify the responsibilities of DHS and OHA in determining eligibility for and administering public assistance and medical assistance.
2. Conforms state medical assistance application and eligibility statutes with changes in federal law (Sections 41-44 and Section 77).
3. Authorizes delegations of authority between OHA, DHS and the Insurance Exchange (Section 96).
4. Requires OHA to establish a program to provide grants to CCOs to fund pilot projects to improve patient engagement and accountability. The bill also establishes the Task Force on Individual Responsibility and Health Engagement to develop recommendations (Sections 100-103).

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Implementation of State and Federal Health Insurance Reform Measures
HB 2240

Background: In March 2010, President Obama signed major health care reform legislation into law. The Affordable Care Act (ACA) makes significant changes to health insurance regulation, such as prohibiting preexisting condition exclusions, requiring coverage of essential health benefits at specific actuarial value levels, guaranteeing access to coverage regardless of health condition, and specifying health insurance rating factors. States that fail to enforce these and other provisions of the ACA are subject to enforcement of these provisions by the federal government. States that fail to enforce the ACA also risk significant fines for their domestic health insurers.

In general, the ACA preempts Oregon laws that conflict with the federal provisions in a way that is less protective for consumers. The 2011 Legislature, in passing Senate Bill 89, eliminated inconsistencies with the "early" reforms of the ACA – those that took effect prior to 2014.

Concept: In an approach consistent with SB 89, HB 2240 implements the provisions of the ACA that take effect in 2014 by eliminating impermissible inconsistencies within the Insurance Code. These provisions include the following:

- Authority to define essential health benefits according to federal law and guidance.
- Definition of "pre-existing condition" in accordance with federal law; insurers cannot exclude or deny coverage to Oregonians based on a pre-existing condition.
- Repeal of portability statutes and requirements in light of the ACA's guaranteed issue provisions and a requirement that all portability plans be discontinued by December 31, 2013.
- Authority for the department to regulate multistate plans by including multistate plans in the definition of "transacting insurance." This ensures that these plans are subject to the same regulations as plans sold only in Oregon and makes certain that all Oregonians enjoy the same protection under the Insurance Code.
- Authority for the department to establish by rule a risk adjustment mechanism.
- Changes to Oregon statutes relating to small group and individual rating factors to conform to the requirements of the ACA. Under the ACA, rating factors for the individual and small group markets are limited to composition (individual or family), geographic rating areas, age and tobacco use.
- Requirements for insurers to pool all individual (exchange and outside) market risks (excluding grandfathered) and all small group (exchange and outside) market risks (excluding grandfathered).
- Changes to the statutory definition of small group from 2 to 50 to 1 to 50 in 2013 with a delayed provision that will change the definition to 1 to 100 in 2016.
- Modification of the Oregon clinical trials mandate to be consistent with the ACA mandate.

- A provision that allows carriers to ask a person to respond to health-related questions but only for the purpose of managing the individual's health care and not to deny coverage.
- A definition of individual health benefit plan consistent with federal law.
- Authority to streamline insurer notice requirements to ensure compliance with ACA and encourage administrative efficiency.
- Repeal of the small employer health insurance basic plan requirements in light of the ACA's essential health benefit and actuarial value requirements.
- Authority for the department to determine requirements for student health benefit plans to ensure they are consistent with the ACA.
- Changes necessary to operate a health insurance exchange in Oregon, including amending grace periods; granting authority by rule to impose and standardize open and special enrollment periods.
- Abolishing the Office of Private Health Partnership and the Family Health Insurance Assistance Program.

If the department receives additional clarification of federal regulation, the department will propose additional changes to this concept through the amendment process.

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