ACA Implementation—Monitoring and Tracking

Oregon

Site Visit Report

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EXECUTIVE SUMMARY

Oregon has made significant strides toward implementing the Affordable Care Act (ACA). It was one of the first states to pass legislation establishing a health insurance exchange as required under the ACA. Oregon has also passed other legislation to prepare for health insurance reforms in the ACA. As an Early Innovator grantee, Oregon also has made substantial progress in ensuring that its information technology systems are ready to determine eligibility for Medicaid or tax credits. While not yet a top priority in its reform efforts, Oregon is also well positioned to implement the Medicaid expansion, in part because of the state's long track record in expanding program eligibility to higher income individuals and to populations not generally covered, such as childless adults. Oregon's successes so far in implementing the ACA can be attributed to already having passed many elements of the law as part of its own health reform efforts, having a strong commitment from top policymakers, including the governor, and making the ACA compatible with Oregon values.

Health Insurance Exchange: Planning and Implementation – Oregon was one of the first states to enact legislation to establish a health insurance exchange under the ACA. Passed during the 2011 legislative session, the exchange garnered support from legislators across the political spectrum. Oregon's exchange law created an independent public corporation, with authority to establish rules and raise revenue through assessments on health insurance carriers. While passing with bipartisan support, the legislative debate was not without controversy. Two main issues surfaced: One centered around whether the exchange would act as an "active purchaser," and the second concerned the inclusion of health insurance companies, providers or insurance brokers on the exchange's board of directors. As to the former, while the language of the statute does not convey authority to the exchange to negotiate directly with plans, state leaders believe there are several options to enhance plan competition and help make products more affordable. For the latter, industry stakeholders are on Oregon's exchange but their participation was limited to two voting members out of nine total members.

Exchange officials have many critical issues ahead of them, including a plan for public education and consumer assistance, designing strategies to protect against adverse selection, the role of agents and brokers, whether to establish a Basic Health Program, and whether to use the federal risk adjustment program or run its own. In addition, to encourage small business participation, exchange officials are considering a defined contribution model with broad employee choice of plans.

Health Insurance Exchange: Enrollment and Subsidy Determinations – Oregon is well on its way to having its information technology system ready to process applications for both prospective Medicaid and exchange participants come October 2013. Oregon's plan for its system is to move away from the state's current siloed system, with separate systems for every program that do not "communicate" with each other, to a "seamless" eligibility and enrollment system and processes. A vendor contract was signed in June 2011. The plan is for a single web-based interface that will determine in real time for most individuals their eligibility for tax credits within the exchange or their eligibility for Medicaid. Eventually, eligibility and enrollment for social services will be done through the same system. In large part, progress has been rapid because several years ago Oregon's Department of Human Services (DHS) had begun a department-wide technology modernization effort for all of its human services eligibility systems.

Exchange officials are fully aware that public education, marketing, and assistance to individuals and businesses will be essential to the exchange's success. They intend to learn from and build upon the state's successful efforts to enroll children in

Healthy Kids, Oregon's publicly subsidized program for children in low- and moderate-income families launched in 2009.

Insurance Reforms – Passed with little controversy, Oregon enacted legislation that provides the state with clear authority to enforce the ACA consumer protections that went into effect on September 23, 2010. In addition, on balance, the state has had few problems with insurance carriers relating to the ACA's early reforms. Perhaps the most unique state action relative to the ACA's early market reforms is the creation of a "reinsurance pool" to stabilize the child-only insurance market and ensure that commercial carriers continue to offer new policies to children under 19. The pool was created in response to several commercial carriers threatening to stop issuing child-only policies. Another early reform in the ACA, the temporary high-risk pool, has had low enrollment, in part because since 1989 Oregon has operated its own high-risk pool.

Oregon expects it will need additional legislation to bring the state into compliance with the insurance reforms scheduled to go into effect in 2014. State regulators intend to commission some actuarial modeling of the impact of the 2014 reforms in order to gauge the impact on premiums in the individual and small group market. Oregon is concerned that the ACA's requirement to expand the small group market from 50 to 100 employees could cause some larger employers to self-insure and escape key federal reforms and state regulation.

Medicaid Policy – Oregon is projected to experience nearly a 50 percent increase in Medicaid enrollment with the ACA Medicaid expansion, though some of the new enrollees will be transitioned from the Oregon Health Plan Standard, a long-running component of the state's Medicaid 1115 waiver in which enrollees receive a reduced benefits package. The state is worried whether there will be sufficient primary care capacity to meet the new demand, but it hopes that with implementation of Coordinated Care Organizations (CCOs) some of these concerns will be mitigated. Still under development, the vision behind CCOs is that they will be community-based organizations that will provide and coordinate medical, dental and behavioral health services. Replacing current Medicaid managed care plans, CCOs will receive a fixed global payment and be held accountable for certain quality outcomes and metrics. The hope is that if CCOs can streamline and improve the efficiency of the health care system, primary care will be sufficient to meet the increased demand likely to occur under reform.

Oregon is exploring the possibility of establishing the Basic Health Program (BHP). The state is well aware that BHP makes insurance more affordable for enrollees and would help reduce individuals from churning on and off Medicaid. At the same time, though, the state is concerned about the affordability of BHP and how it might affect the viability of the exchange.

Provider and Insurance Markets – Oregon's health care market is organized largely by geographic regions and populated primarily by locally owned and operated providers, not large national corporations. Indeed, because Oregon's health care market is organized at the local levels and providers and health plans are largely "homegrown," the state is optimistic that CCOs, which push responsibility for health care to the local level, will work and generate considerable savings. Oregon's commercial insurance market is relatively competitive compared to many other states. Most of the carriers are "domestic"; large national carriers have not gained much of a foothold in the state. Oregon's competitive insurance market has placed carriers at a disadvantage relative to providers, many of which are hospital-based systems that carriers must include in their networks in order to remain competitive.

Health care providers and insurance firms were generally supportive of Oregon's health care efforts. While each group liked and disliked different elements of the reforms, the state appears to have successfully made the case to stakeholders that it cannot continue to finance the current health care system without changes. Though not universal, Oregon's business community was similarly supportive of the state's health care reform efforts.

Conclusions – Oregon is well on its way to fully implementing the ACA as well its own health reforms by January 1, 2014.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses.[1] The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

BACKGROUND

Oregon has made significant strides toward implementing health care reform—both the ACA and the state's own health reforms. Oregon was one of the first states in the country to pass legislation establishing the Health Insurance Exchange (HIX) required under the ACA. Signed into law by Governor John Kitzhaber (D) in June 2011, Senate Bill 99 (SB 99) passed with strong bipartisan support in both legislative chambers. Beginning in 2014, the state estimates 1 million Oregonians, including Medicaid enrollees, will be served by its statewide HIX, which was established as an independent public corporation.[2] The first meeting of the HIX board, which the governor appointed and the Senate confirmed, was held in September 2011.

Oregon has also passed other important pieces of legislation to prepare for health insurance reforms in the ACA, including legislation (SB 89) that amends Oregon's insurance code to meet the standards in the ACA, as well as legislation that establishes a requirement for the bronze and silver benefit plans offered under the HIX. In addition, the state has made substantial progress in ensuring that its information technology (IT) systems are ready to provide state residents with a website that will determine eligibility for Medicaid or tax credits when the HIX goes into effect in September 2013, as prescribed under the ACA. An Early Innovator Grantee, Oregon contracted with a vendor in May 2011 to help the state build an IT infrastructure that will meet the ACA eligibility and enrollment requirements.

Oregon was one of the first states in the country to pass legislation establishing the Health Insurance Exchange (HIX) required under the ACA.

As we discuss below, study respondents of all stripes—from small businesses to health plans to state officials—were, on balance, enthusiastic and supportive about the many activities surrounding Oregon's implementation of the ACA. Moreover, state officials were described as being highly engaged in the process. In large measure, the seeming ease with which the state is moving forward with implementation of the federal law was attributed to Oregon's having already passed many of elements of the ACA as part of its own health reform efforts, including an Oregon HIX and expanding Medicaid coverage. As one respondent put it, the ACA was a bit of a "yawn" for Oregon, as it had already fought the difficult political battles needed to implement major elements of national reform, which gave Oregon a significant head start in preparing for health reform.

At the same time, state officials readily acknowledge that passage of the ACA provided them "clarity" on how to move forward, as well as funds that they otherwise would not have had and that were much needed, given Oregon's fiscal picture. In addition, officials noted that a critical ingredient in the state's successes to date is that they have reframed the discussion to be about implementing health reform in Oregon with an Oregon model with Oregon values, rather than a national reform model.

Long considered a health care trailblazer, Oregon's reform efforts date back to at least the late 1980s, when the state, among other things, created the Oregon Medical Insurance Pool, which offered health benefits to individuals who could not buy insurance, as well as an employer mandate, which was ultimately not implemented. These initiatives were followed by an effort to redefine the benefit package for some Medicaid enrollees to expand coverage to all Oregonians with incomes less than 100 percent of poverty.[3] A major feature of that initiative was to limit health care services for Oregon's Medicaid program based on what is referred to as the Prioritized List of Health Services (which ranks services based on clinical effectiveness) to help pay for the coverage expansion. Vestiges of these, as well as many of the state's other private and public health care initiatives, still exist in Oregon today, including the Prioritized List and parts of the Medicaid coverage expansion.

Officials noted that a critical ingredient in the state's successes to date is that they have reframed the discussion to be about implementing health reform in Oregon with an Oregon model with Oregon values.

Continuing its tradition of pushing the health care envelope, Oregon has passed significant health care reform legislation in the last two legislative sessions. In 2009, under the leadership of then-Governor Kulongoski, Oregon passed two companion bills (HB 2009 and HB 2116) that included provisions to expand coverage to all children, brought more low-income adults into Oregon's Medicaid program, and created a business plan for an HIX. The 2009 legislation also established the Oregon Health Authority (OHA), which was charged with leading the state's health care reform efforts as well as purchasing health insurance for Medicaid enrollees, state employees, and school teachers. With all populations combined, the OHA has responsibility for buying health insurance for some 850,000 individuals, about one in four Oregonians.[4] The goal behind this purchasing consolidation is to lower state health care costs, but also to change how Oregon delivers and pays for health care. In July 2011, OHA officially separated from the Department of Human Services. Finally, the legislature gave the Division of Insurance (DOI) new authority to review the rates of commercial health insurers.

In 2011, Oregon passed legislation establishing coordinated care organizations, or CCOs.[5] While the ACA expanded coverage, Oregon officials felt that federal health care reform did not go far enough to contain growing health care costs or improve quality of care. Believing that Oregon's health care costs are becoming increasingly unsustainable, the state has adopted the CCO initiative as one of several strategies with the hopes of bending the health care cost curve.

Described by one respondent as, "accountable care organizations on steroids," CCOs will be community-based organizations that will provide and coordinate medical, dental and behavioral health services. CCOs, described in more detail later, will receive a fixed global payment and be held accountable for meeting certain quality outcomes and metrics. By making CCOs responsible for the full array of services and paying them a fixed amount, the state hopes that these new entities will save money while improving quality. Scheduled to be implemented in July 2012, the first group to be enrolled in CCOs will be Medicaid beneficiaries. Before CCOs can be launched, however, several important steps must be taken, including getting final approval by the Oregon legislature and Medicaid waivers from the federal government. The state's vision is that OHA will eventually enroll state employees and teachers in CCOs.

As in other states, employer-sponsored insurance is the most common type of health coverage for Oregonians. In 2011, an estimated 56.4 percent of state residents (roughly 1.9 million individuals) have health insurance coverage through an employer-sponsored health plan.[6,7] The next largest insurers are Medicaid and the Children's Health Insurance Program (CHIP), which cover 14.2 percent of Oregonians (about 475,000 individuals). An estimated 20.2 percent of state residents (about 678,000) have no health insurance. Once the ACA is implemented, estimates suggest that 317,000 Oregonians will gain coverage under Medicaid and CHIP; 226,000 will gain coverage through the HIX; and uninsurance in the state will drop to 9.5 percent, down from 20.2 percent.

HEALTH INSURANCE EXCHANGE: PLANNING AND IMPLEMENTATION

Oregon was one of the first states to enact legislation (SB 99) to establish an HIX under the ACA (see text box for key elements of SB 99).[8] The concept of an exchange is not new in Oregon. In 2006, then-Governor Kulongoski tasked the Oregon Health Policy Commission with developing recommendations for health care reform in the state.[9] One of the commission's recommendations was to create an exchange, which was considered during the state legislature's 2007 session. While there was broad support for an exchange as a mechanism to expand insurance coverage for Oregon residents and small businesses, the state's budget made it difficult to finance the necessary subsidies. As a result, the legislature created a citizen-led Health Fund Board to study the issue further, but deferred legislation creating an exchange. During the 2009 legislative session, there was considerable discussion and support for an exchange, but again, the state lacked sufficient funds to establish one. Instead, the Oregon Health Policy Board was tasked with developing a business plan for an exchange, pending sufficient resources.

The passage of the ACA gave Oregon the financial resources it needed to move forward with a program state officials had been planning since 2006. When SB 99 passed during the 2011 legislative session, it garnered support from legislators across the political spectrum. Respondents believe they have been able to avoid some of the political strife over exchanges they have observed in other states because Oregon has been working for so long on systemic reforms, and the ACA in many ways represents just a point along the state's long-term trajectory.

Signed on June 22, 2011, Oregon's HIX law creates an independent public corporation, with authority to establish rules and raise revenue through assessments on health insurance carriers. The law exempts the exchange from certain state personnel and procurement requirements, giving the entity greater flexibility in hiring and contracting than state executive branch agencies. Once SB 99 was passed, Governor Kitzhaber moved

Key Provisions of Oregon's Health Insurance Exchange Legislation (SB 99)

- Establishes Oregon Health Insurance Exchange (OHIE) as a public corporation that, while not considered a unit of state government, has authority to exercise governmental powers and perform governmental functions.
- Exempts the OHIE from certain rules applicable to state government agencies, including personnel and contracting rules.
- Establishes a governing board with nine members, seven to be appointed by the governor and confirmed by the Senate, and two of whom are ex officio, as follows:
  - Director of the Oregon Health Authority (or designee)
  - Director of the Department of Consumer and Business Services (or designee) to represent the Division of Insurance
- Requires that at least two of the board members must represent consumers, and no more than two members can represent the health care industry.
- Requires the OHIE to perform the exchange functions detailed in the ACA, including certifying, recertifying, and decertifying qualified health plans; creating a web portal to allow plan-to-plan comparisons; assisting individuals with enrollment and certifying entities to be navigators; grading health plans based on price and quality; and certifying exemptions from the individual responsibility requirement.
- Requires the OHIE to establish standardized health benefit plan options.
- Requires the OHIE board to appoint an executive director.
- Establishes a Consumer and Small Business advisory group, as well as the authority to convene other advisory groups as needed.
- Provides authority to adopt rules to run the exchange and impose assessments on insurance companies to finance the exchange.

quickly to name an interim executive director and nominate members of a governing board. The Senate approved those nominees on September 22, 2011. The HIX was incubated within OHA, but is now operating as a separate, independent entity, called the Oregon Health Insurance Exchange Corporation.[10]

To make the exchange operational, exchange officials are currently working in several critical areas. First, a team is working on external relations—soliciting and incorporating feedback from board members, state agency heads, state legislators, stakeholders (insurance industry representatives, agents and brokers, small business representatives, and consumer groups), the media, and the public. Consumer and small business groups meet regularly with exchange staff, as do representatives of insurers and brokers. Board meetings are open to the public and streamed live via the web.[11]

Second, staff have drafted a detailed work plan for exchange operations, including such key functions as plan management (including standards for participating health plans and a program to "grade" plans based on quality, care coordination, and network adequacy), billing and premium collection, eligibility and enrollment, essential health benefits, navigators, and evaluation. They are also collecting and analyzing critical data about the size of the individual and small group markets, modeling the likely effects of the Medicaid expansion and insurance reforms on premiums, working with contractors to develop the IT infrastructure, and developing business processes.[12]

While the language of the statute does not explicitly convey authority to negotiate with health plans, the exchange's leaders believe they have a number of options to enhance plan competition and help individuals and small businesses access more affordable products.

Third, like any small business, the exchange must provide for internal administration: financial management, human resources, contracting and facilities. The exchange has been financing its operations through federal exchange grants (an Early Innovator grant, a planning grant, and a Level 1 establishment grant of approximately $8.9 million), but staff are developing long-term financing models. The primary financing mechanism will likely be a fee on participating HIX health plans, but officials are exploring other sources of revenue, including the option of providing back-office eligibility and enrollment services to other states' HIXs.

Exchange officials recognize that they have yet to determine a clear strategy on a number of other critical issues, including a plan for public education and consumer assistance, the role of agents and brokers, and whether to use the federal risk-adjustment program or run its own.[13] To some extent, the state must wait for further federal guidance on these issues before the officials can make final decisions. In addition, HIX officials recognize the need to protect the exchange against potential adverse selection, and have executed an agreement with the DOI that includes: (1) a delineation of roles and responsibilities of the exchange and Oregon's DOI relating to qualified health plans inside and outside the exchange, and (2) a strategy for limiting adverse selection between the exchange and the outside market, including the identification of necessary legislation to ensure a level playing field.[14] To encourage small business participation, HIX officials are considering a defined contribution model with broad employee choice of plans.[15] In addition, since its first meeting on September 30, 2011, the board has appointed a permanent executive director, approved bylaws, and adopted a mission statement. As of this writing, the board is working to develop a governing model, draft a vision statement, and finalize the business plan.

The next major hurdle for the Oregon exchange is legislative review and approval of the business (operational) plan. A draft of the plan has been posted on the HIX's website, and the final plan will be presented to the legislature in February 2012.[16] Recognizing the importance of legislative support and buy-in, exchange officials are providing regular updates to legislative leaders.

Policy Issues: Decisions Made and Sources of Controversy

The exchange bill passed both houses of the legislature with bipartisan support. However, the legislative debate was not without controversy. In particular, consumer groups mounted an unsuccessful effort to ensure that the exchange would act as an "active purchaser" and negotiate with health plans on behalf of enrollees.

While the language of the statute does not explicitly convey authority to negotiate with health plans, the exchange's leaders believe they have a number of options to enhance plan competition and help individuals and small businesses access more affordable products. For example, exchange staff have discussed requiring plans to standardize benefits beyond what is required under the ACA. In addition, the state is considering the CCOs as potential participants in the exchange, which could provide competition for existing commercial carriers. Exchange officials intend to encourage broad insurer participation, at least initially, but they also believe they have the authority to selectively contract with health plans if in the interests of enrollees. They note that the major local carriers have expressed interest in participating in the exchange and are working constructively with HIX officials. While some are more measured in their enthusiasm, at least one major commercial carrier has expressed a strong desire to participate.

During the legislative process, consumer advocates and other groups protested the composition of the exchange's board of directors, opposing the inclusion of any representatives of health insurance companies, providers or insurance brokers. They argued that such representatives would inevitably have financial conflicts of interest precluding them from making decisions solely in the interests of exchange enrollees. While consumer groups were not able to keep industry stakeholders off the board entirely, they did succeed in limiting their participation to a maximum of two voting members.

Legislators also grappled with the role of health insurance producers (i.e., agents and brokers). Some felt strongly that broker fees should not be included in the rates paid by exchange enrollees, pushing for them to be compensated through a separate add-on fee. However, exchange officials want to work with producers, particularly to encourage small business enrollment. They have suggested that the exchange could deploy agents on its behalf, authorizing them to work with all the participating carriers to bring in enrollees.

In general, key business and industry leaders have been cooperative in the state's efforts to move forward. Representatives of major commercial insurers, and insurance agents and brokers meet regularly with exchange staff to discuss emerging issues and provide expertise. While some in the small business community supported "active purchaser" language during the legislative debate, small business leaders–including the Oregon chapter of the National Federation of Independent Business (NFIB)—endorsed SB 99 and have played an active advisory role. Of the nine-member board of directors, four members are representatives of small business.[17]

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Consumer groups' relations with state exchange officials started off strained, stemming largely from the legislative debate over SB 99. A coalition of consumer advocates opposed final passage of the bill because it did not include the language they had sought, allowing the exchange to negotiate premium rates with health plans. They also objected to including industry representatives on the governing board. Leading advocates felt shut out at key points during the legislative debate. However, officials with the exchange and consumer groups acknowledge that they need to collaborate in order to make the exchange a success, so they are working to rebuild relationships that were frayed during the legislative debate. An Individual and Small Employer Consumer Advisory Committee, established under Oregon's HIX legislation, is meeting regularly to assist in the planning and development of the exchange.[18]

HEALTH INSURANCE EXCHANGE: ENROLLMENT AND SUBSIDY DETERMINATIONS

Oregon's exchange officials are working with other state agencies to foster interoperability among state programs, with the goal of achieving "seamless" eligibility and enrollment processes for consumers. Staff are reviewing the common eligibility elements among existing subsidized programs and mapping them to the

federally required eligibility elements for the exchange.[19] The state's health IT coordinator, DOI staff and Medicaid director hold regular meetings to ensure collaboration.

Going forward, exchange officials are close to executing an agreement with the state Medicaid agency that includes a delineation of respective roles and responsibilities, identifies eligibility and enrollment challenges, maps out strategies to ensure compliance with "no wrong door," and provides operating procedures for interaction between the exchange and other state programs.[20]

Oregon is well on its way to having its IT system ready to process applications for both prospective Medicaid and HIX participants come October 2013, the date by which the U.S. Department of Health and Human Services, proposed rule requires states to have their enrollment systems in place. Oregon's plan for its IT eligibility enrollment system is to move away from the state's current siloed system, with separate systems for every program that do not "communicate" with each other, to an enterprise system. Under the enterprise system, Oregon is building over its current collection of systems and using a technology platform in which it can configure, rather than build, the pieces it needs for multiple purposes. At present, the state is focused on ensuring that the Medicaid and HIX components are fully operational when the ACA eligibility expansion takes place. The plan is for a single, web-based interface that will determine in real time for most individuals their eligibility for tax credits within the HIX or their eligibility for Medicaid. Eventually, eligibility and enrollment for all social services (e.g., Temporary Assistance for Needy Families and Supplemental Nutrition Assistance Program) will be done through the same background system, but not the same interface.

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In June 2011, Oregon signed a contract to purchase Oracle's Policy Automation product. State officials described the Oracle product as being highly flexible, nimble and easy to use. Oracle will install its platform or "collection of tools" that state staff, to a very large extent, will be able to change or reconfigure as needed. This capability to make changes was likened to changing a Facebook page, where, for example, an individual uploads a picture. Such a change does not entail coding because the tool is made to be configured, not developed. Knowing that they needed a system to be ready on a tight timeline, and that there are still many outstanding policy decisions, Oregon officials found the flexibility of the Oracle system particularly attractive. The state is in the process of procuring a system integrator to help tailor the Oracle software for Oregon. As of fall 2011, Oregon had begun the configuration process for the HIX. State officials felt confident that the system would be fully ready to launch come September 2013.

In large part, progress has been rapid because several years ago the Oregon Department of Human Services had begun a department-wide IT modernization effort for all of its human services eligibility systems. Indeed, in 2009, a joint DHS and OHA enterprise technology plan was adopted. While Oregon is advancing quickly with its IT plans, state officials readily acknowledge that they are struggling with many eligibility and enrollment issues: Who should be doing the actual eligibility determination? Should eligibility determination be done by one shared system, or should it be done by the exchange, with Medicaid delegating to it? When people want to make a phone call to ask about enrollment, who should they call? Who should that person work for? How much of eligibility and enrollment can be automated? How can individuals currently eligible for Medicaid enroll in the program online?

Exchange officials are fully aware that public education, marketing and assistance to individuals and businesses will be essential to the exchange's success. They intend to learn from and build upon the state's successful efforts to enroll children in Healthy Kids, Oregon's publicly subsidized program for children in low- and moderate-income families, which was launched in 2009. Under the Healthy Kids initiative, Oregon has cut the number of uninsured children in half. Officials attribute much of this success to a significant outreach effort, which respondents described as "largely old-fashioned advertising." Healthy Kids also deployed community-based organizations to help with application assistance and enrollment, and this effort could serve as a model for the Navigator program, which is required by the ACA.

Exchange respondents express frustration with restrictions in federal law that have constrained their ability to develop a comprehensive approach to public education and consumer assistance. Under the ACA, the Navigator program cannot be financed with exchange grant funds.[21]

The exchange, however, will need to have a strong outreach campaign beginning in 2013 to give individuals the information and assistance they need to apply for premium subsidies and enroll in a plan during the initial open enrollment period (proposed to begin October 1, 2013).[22] The ACA does authorize a federally funded consumer assistance program (CAP) to educate and provide information to consumers with insurance-related problems.[23] The Insurance Division of Oregon's Department of Consumer & Business Services received an initial CAP grant in October 2010, but Congress appropriated only one year of funding. To maintain a robust program of consumer education and assistance, the state applied for funding through a federal exchange establishment grant. However, HHS officials argued that such funding could only be devoted to outreach to potential exchange enrollees, not the broader Oregon public. Once CAP funding ended, Oregon began using exchange funding to support CAP staff providing help to uninsured individuals seeking coverage options. This work is targeted at individuals who will likely be eligible to purchase through the exchange in 2014. The Insurance Division has a program to continue to assist insured individuals with appeals or other complaints related to their coverage. The latter program is funded with state dollars, while the assistance provided by the exchange is funded through the federal establishment grant.

Exchange officials are fully aware that public education, marketing, and assistance to individuals and businesses will be essential to the exchange's success. They intend to learn from and build upon the state's successful efforts to enroll children in Healthy Kids, Oregon's publicly subsidized program for children in low- and moderate-income families, which was launched in 2009.

Given current budget constraints, Oregon is unlikely to provide additional subsidies for premium or cost-sharing assistance to individuals in the exchange. However, Oregon has a history of using state funds to help consumers and small businesses purchase insurance, for example, through the Family Health Insurance Assistance Program (FHIAP), a premium assistance program that Oregon started in 1997. While FHIAP has lost funding because of state budget cuts, if the fiscal situation improves, state officials noted that this program could be tapped to supplement federal premium and cost-sharing subsidies to low- and moderate-income families inside HIX.

INSURANCE REFORMS

Implementation and Impacts of the ACA's Early Market Refrms

Oregon has enacted legislation (SB 89) that provides the DOI with clear authority to enforce the ACA consumer protections that went into effect on September 23, 2010.

The legislation hews closely to the standards established in the ACA and was passed with little fanfare or controversy, according to respondents.[24] In fact, state officials noted that a conservative Republican carried the bill in the Senate and a liberal Democrat carried the bill in the House. In general, the DOI has had few problems with insurance carriers relating to the ACA's early reforms, although DOI respondents flagged an early attempt by one carrier to delay implementation past the required effective date. In that situation, the DOI made clear that it would use all available regulatory tools to enforce the deadlines set by federal law. The carrier backed down and came into compliance at the prescribed time. The DOI has been working one-on-one with all the carriers to try to answer technical and interpretive questions surrounding the new reforms. Both sides express considerable frustration with the effectiveness, timeliness and clarity of guidance coming from federal officials. Having a second, federal layer of insurance regulation is a new phenomenon for state regulators and carriers alike, and will require adjustments and flexibility on all sides. State regulators, however, note that they often have difficulty getting the information they need when they need it from their federal counterparts.

Highlights of Insurance Reforms in SB 89

- Guaranteed issue and elimination of preexisting conditions for children under 19.
- Requirement to allow children up to age 26 to stay on a parent's policy.
- Elimination of cost sharing for evidence-based preventive benefits.
- Prohibition on rescissions.
- Restrictions on annual dollar coverage limits.
- Prohibition of lifetime dollar coverage limits.
- Access to out-of-network emergency care.
- Access to choice of primary care and OB/Gyn providers.

The DOI has been assertive in monitoring carriers' descriptions of the ACA's early reforms in their marketing materials. After implementing the SB 89 reforms, some of Oregon's insurance companies told enrollees that the ACA's new protections were responsible for their entire premium increase. The DOI viewed this as misleading and began requiring carriers to submit samples of their communications to enrollees as part of rate review, clamping down on efforts to attribute premium increases to the ACA without supporting evidence. In fact, the DOI has found that the ACA's early consumer protections have had a negligible effect on premiums. There has, however, been a fair amount of consumer confusion about their new rights, particularly relating to their health plan's grandfathered status.[25] Consumers generally do not know whether or not their plan is grandfathered, and the DOI has fielded numerous calls stemming from that confusion, with callers being unclear whether specific ACA protections apply to their plan.

Perhaps the most unique state action relative to the ACA's early market reforms is the creation of a "reinsurance pool" to stabilize the child-only insurance market and ensure that commercial carriers continue to offer new policies to children under 19. The ACA requires that issuers cover children under 19 regardless of health status and without any preexisting condition benefit exclusions.[26] Shortly after this provision of the law went into effect, a number of commercial carriers in Oregon told regulators they would stop issuing new child-only insurance policies. In response, state leaders brought the major insurance companies together and negotiated an agreement to establish a reinsurance pool, supported by the companies and protecting them from adverse selection in the child-only market.

Several state respondents highlighted both the creativity of this model (to their knowledge the only one of its kind nationwide) and the cooperation of the industry to develop a workable program. The result was quick passage of Senate Bill 514, the Oregon Children's Reinsurance Program.[27] The program creates a reinsurance pool, allowing carriers to assess a child's risk profile through a standardized health statement. The carrier can then decide whether to cede risk to the reinsurance program, run by Oregon's high-risk pool (the Oregon Medical Insurance Pool, or OMIP). The program is funded through biannual retrospective assessments, and carriers can use any reimbursements under the program to reduce their OMIP assessment.

The program will expire on January 1, 2014.[28] State officials universally call this program a success, and carriers are continuing to offer child-only policies. This program may also serve as the state's model for the broader reinsurance program required by the ACA to begin in January 2014.

The DOI has largely found carriers to be in compliance with the ACA's early market reforms, but some of them have had different interpretations of the details of the law. For example, the DOI began to receive calls from consumers, complaining that they were being charged copayments or deductibles for screening colonoscopies, one of the preventive benefits insurance companies are required to cover without charging a deductible or copayment. At issue was whether a colonoscopy constituted a preventive screening if other services were performed. After an investigation, the DOI intends to issue a bulletin to clarify the requirements of the law in relation to screening colonoscopies, so that patients are not inappropriately charged.

Another early reform in the ACA, the temporary high-risk pool (the Pre-Existing Condition Insurance Plan) has had low enrollment. DOI respondents speculate

this is in part because there was little pent-up demand, largely because since 1989 Oregon has operated its own high-risk pool, OMIP. OMIP was created for individuals who were turned down for coverage because of medical conditions. It also provides portability coverage for Health Insurance Portability and Accountability Act-eligible individuals leaving a group plan. OMIP rates can be no more than 125 percent of insurers' standard rate, and individuals under 200 percent of poverty are eligible for state-subsidized premium assistance. In 2010, Oregon enacted House Bill 3659, which added the ACA's high-risk pool to OMIP. The two pools are governed side-by-side by the OMIP board. As of July 2011, OMIP's enrollment was 12,758, and the federal high-risk pool's enrollment was 981.[29]

Planning for the Insurance Reforms of 2014

The DOI has developed a plan to respond to the release of federal guidelines on minimum essential health benefits (EHB). Because the ACA requires states to make up any difference in cost between the federal minimum and state-mandated benefits, the state's plan includes a review of existing state laws requiring coverage of certain items, such as prosthetics and orthotics, as well as services, such as autism treatment and diabetes management. The review will also include a data call to the state's health plans, asking them to report the specific costs associated with Oregon's benefit mandates. While DOI officials were anticipating some controversy over which mandates to maintain and which to repeal, it is possible they could sidestep some of that controversy because of recent guidance issued by HHS. On December 16, 2011, HHS released a bulletin on essential health benefits suggesting that, instead of one national standard for EHB, states may choose among four benchmark options for their EHB: (1) the largest small employer plan in the state, (2) any of the three largest state employee health benefit plans, (3) any of the largest three national Federal Employee Health Benefits Plan options, or (4) the largest commercial health maintenance organization operating in the state. If Oregon officials choose a benchmark plan that already includes existing state benefit mandates, they will be included as part of the minimum EHB, and the state will not need to account or pay for them as additional benefits.

The DOI expects it will need additional legislation to bring the state into compliance with the insurance reforms scheduled to go into effect in 2014.

The DOI expects it will need additional legislation to bring the state into compliance with the insurance reforms scheduled to go into effect in 2014. At this stage, officials have not discussed going beyond the minimum requirements established by the ACA, such as imposing more restrictive age rating than required under the ACA or whether to have tobacco-use rating. The ACA's rating factors are similar to what already exists in Oregon's individual market, and regulators are concerned that a move to pure community rating or narrowing age bands could make health insurance too expensive for younger people. State regulators intend to commission some actuarial modeling of the impact of the 2014 reforms in order to gauge the impact on premiums in the individual and small group market. In particular, they are nervous that the ACA's requirement to expand the small group market from 50 to 100 employees could cause some larger employers to self-insure and escape key federal reforms and state regulation.[30] State regulators also anticipate some consolidation among their commercial insurers as a result of the 2014 reforms, and expect that one or two of their for-profit insurers will leave the individual market, in part because the state's rate review efforts have made a significant dent in their profit margins.

Focus on Affordability: Medical Loss Ratio and Rate Review

Oregon has a competitive insurance market, with seven major commercial carriers that compete "fiercely" for market share. Four of the seven are nonprofit, and DOI respondents noted that all of their carriers have a medical loss ratio (MLR) above the 80 percent required by the ACA. The DOI has not received any requests from carriers to pursue an application with HHS to lower the MLR standard. Further, it has no plans at this time to take on enforcement of the MLR—as one DOI respondent put it, "we're not looking for extra enforcement duties." They will leave the necessary financial audits and calculation of rebates to HHS.

As they have across the country, carriers have been changing the way they compensate insurance agents and brokers, largely by moving away from a percentage of premium to a "per member per month" set fee. DOI respondents attribute this to the carriers' efforts to compete on administrative costs and not to implementation of the MLR standard. And unlike their national counterparts, Oregon agents and brokers have done little lobbying to urge that agent/broker compensation be excluded from the MLR calculation.

Oregon is nationally recognized for its rate review program.[31] State respondents note that their efforts to

enhance rate review began well before passage of the ACA, and the federal law's primary impact has been to help fund more staff to conduct the reviews and communicate the complexities of the filings to the public.

The federal rate review grant allowed the DOI to hire two new actuaries, ensuring that each filing receives a thorough examination. The DOI also hired a market analyst, who assesses and verifies the market data each carrier submits with its filing, and has launched a series of public hearings over specific rate increase requests.

Oregon's DOI has "prior approval" authority over rates in the individual and small group market, meaning that carriers cannot implement a rate until the DOI has approved it.[32] However, some plans sold through associations, if they meet certain standards, are considered exempt from review.[33] HHS has deemed Oregon to have a partially effective rate review process. It is considered effective for its review of products in the traditional individual and small group market, but not for association plans that are exempted from rate review.[34] As a result, HHS defers to Oregon's review for traditional individual and small group products, but will conduct its own review of exempted association products.

For traditional market products, Oregon has instituted a rigorous process of review and unprecedented transparency for rate filings. The federal rate review grant allowed the DOI to hire two new actuaries, ensuring that each filing receives a thorough examination. The DOI also hired a market analyst, who assesses and verifies the market data each carrier submits with its filing, and has launched a series of public hearings over specific rate increase requests. The first hearing, over a proposed 22 percent rate increase from one of Oregon's largest carriers, generated considerable media attention and an audience of more than 150 people.[35] After the hearing, the DOI approved a 12.8 percent rate increase, about 60 percent of the requested rate increase. The second public hearing, which DOI respondents characterized as a "cross between a hearing and a public meeting," reviewed a rate increase request submitted by ODS Health Plan. This hearing generated much less publicity, but provided consumers with an opportunity to raise concerns. DOI respondents believe the hearings will benefit the public and the health plans, particularly as consumers become more educated about the costs that are driving premium increases.

Oregon is focused on two particular areas related to rate review. First, it has made considerable strides in enhancing the transparency of rate filings and translating the complicated information contained within them for consumers. All the documents that a carrier submits to support a rate filing are made public through a website, www.oregonhealthrates.org, and consumers are given 30 days to comment. The DOI has produced a consumer-friendly video, explaining what underlies rate increases and describing the rate review process.[36] In addition, the DOI has subcontracted with a consumer advocacy group to comment on rate requests on behalf of consumers.[37]

Second, the DOI is embarking on an ambitious effort to use rate review to help address some of the underlying drivers of health care cost increases. Legislation passed in 2009 gave the DOI authority to request data on insurance companies' cost containment and quality improvement efforts through rate filings.[38] The DOI is using federal rate review grant funds to support an evaluation of whether Oregon should require insurers to spend a minimum amount on primary care, reject rate requests if an insurer contracts with providers who have not adopted defined best practices, or reject rate increases if provider costs go up by more than a certain percentage per year or are outside the normal range.[39] DOI respondents noted that, while insurers generally dislike rate review, they are receptive to the state's initiative in this area. With a highly competitive insurance market, but a relatively concentrated provider market, many hospital-based providers hold the upper hand in negotiating contract terms with insurance carriers. If all commercial carriers are required as a condition of rate review to include certain terms in their contracts or hold providers to certain standards, it could give the carriers additional leverage to demand improved quality and efficiency from these providers. The DOI's efforts have garnered support from key legislative leaders, and will be implemented in coordination with the cost containment and delivery system reform strategies developed by the Oregon Health Authority and, ultimately, by the HIX.

However, while the state's overall rate review program receives national accolades, some of the local carriers have raised some red flags. They have been generally cooperative about the greater transparency, but there

has been some grumbling about the length of time for reviews. Even with the added staff, it has been challenging for the DOI to meet deadlines. State respondents noted, "Transparency is the right thing to do, but it creates delay. And taking rate filing information and turning it into plain language is a lot of work."

MEDICAID POLICY

Oregon has about 600,000 individuals enrolled in its Medicaid program, called the Oregon Health Plan or OHP, which has operated under a Medicaid Section 1115 waiver since 1993. OHP has two levels of coverage: OHP Plus, which provides comprehensive coverage to categorically eligible adults and children, and OHP Standard, which provides a reduced benefit package to low-income adults. The benefit package for both OHP Plus and OHP Standard is governed by the Prioritized List of Health Services described earlier.

Budget Pressures and Medicaid

Over the past two budget cycles (2009–2011 and 2011–2013), Oregon has made significant changes to its Medicaid program, both positive and negative. Despite a significant shortfall in the state's budget, in the 2009–2011 cycle health care was made a policy priority and Oregon enacted coverage expansions, including the Healthy Kids program, which expanded coverage to all children in the state. For the Medicaid program, children in families with incomes below 200 percent of poverty were made eligible, up from 185 percent of poverty.[40] Then for low-income adults (those with incomes up to 100 percent of poverty), Oregon reopened its OHP Standard program, whose enrollment has been capped at 24,000 since August 2004. With the 2009 expansion, about 35,000 additional adults gained OHP Standard coverage.

In the most recent budget cycle (2011–2013), Oregon confronted a very challenging fiscal situation that created enormous pressures on Medicaid. The state's fiscal situation, combined with the loss of $1 billion in federal stimulus money, forced the Oregon legislature to enact some major cuts to Medicaid in the 2011–2013 biennium budget, which passed in June 2011. Among the more significant 2011–2013 reductions:

- Most OHP provider rates were cut 11.2 percent over the two-year budget cycle, including reimbursement for physical, mental, dental and managed care capitation rates. The one important exception was that rates for primary care were maintained.
- Benefits were cut: Thirteen services were cut from the OHP Prioritized List.
- OHP administrative costs were reduced by 16 percent.

Apart from these reductions, the 2011–2013 budget assumes $239 million in general fund OHP savings (about $600 million total federal and state) from the implementation of CCOs. The state hopes that by combining services, paying a global payment, and improving alignment of incentives, CCOs will provide care more efficiently and, in turn, generate substantial savings. State officials acknowledge that they are expecting sizable savings from CCOs in a very short time, while cutting Medicaid provider reimbursement. They recognize that this is a tall order for the provider community and the yet-to-be-developed CCOs.

More broadly, Oregon officials expressed concern about whether the state is going to be able to "limp" along until 2014, when most of the ACA funding becomes available. In addition, there was concern that if the state's budget further deteriorates in the next year or two, it will take "some of the air out of the balloon" for health care reform.

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Provider Taxes. Like many other states, Oregon has used provider taxes in its Medicaid program for the past several years. In 2003, for example, Oregon imposed a provider tax on its long-term care facilities that still exists today. Oregon has also had a long-running hospital and Medicaid managed care tax; the latter expired in 2009 due to a federal policy change.

In recent years, again like many other states, Oregon has increasingly relied on provider tax revenue to help finance its Medicaid program. In the 2009–2011 budget, for example, Oregon funded the Healthy Kids program with a new tax on commercial insurance premiums and capitation payments to Medicaid managed care plans. In addition, an increase in the state's long-standing hospital

provider tax funded the reopening of OHP Standard, allowing 35,000 additional low-income adults to gain Medicaid coverage. Then, as part of its 2011–2013 budget, the state again increased taxes on hospitals and managed care plans, largely to help balance its Medicaid budget. While within federal legal limits for use of provider taxes in Medicaid, Oregon officials admitted that because raising revenues by increasing general taxes is now largely not part of state policy discussions, it has become increasingly dependent on provider taxes to finance Medicaid. This reliance has state officials concerned about the new limits on Medicaid provider taxes that are currently being discussed by federal policy-makers.

The ACA and Medicaid

Oregon officials candidly concede that while the ACA Medicaid expansion is certainly on their radar, they have not had time to fully digest or appreciate it. Instead, much of their energy to date has been focused on the HIX. As part of that, Oregon has also devoted considerable effort to developing its IT system to ensure that the state is ready to enroll both HIX and Medicaid enrollees, both new and old. The vision for the system is to make enrollment in Medicaid and HIX seamless or make "Medicaid the 100 percent subsidy" plan. In addition to making IT system modifications and enhancements, OHA is going through a "cultural change" where it is no longer asking "Are you eligible for Medicaid?" but instead asking "What type of insurance are you eligible for?"

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While working on improving their eligibility and enrollment systems and processes, Oregon officials have identified several enrollment and eligibility issues. Chief among them:

- How to handle different types of income separately. For example, how to handle child support as part of income computation. The ACA does not include child support as part of income whereas Medicaid eligibility does. There is concern that by not counting child support, they may artificially inflate the old eligible population, which will have a substantial budget impact on the state. This particularly important for CHIP.
- Verifying income. How can the state "reach into" income data available online and convert them into MAGI terms? And how can this be done in an automated system?
- Would the Centers for Medicare and Medicaid Services consider a Medicaid State Plan Amendment for a state that wants to apply MAGI to all of its eligibility groups?
- How many cases could have their income verified electronically? Oregon estimates that about 40 percent of its current applicants' incomes could be verified electronically. Oregon is looking at an Oklahoma policy that allows for self-attestation of income for Medicaid. However, state officials do not have a good sense of how closely self-reported income actually matches real income.
- Oregon would like to automatically enroll SNAP enrollees into Medicaid. One state figure indicates that there are about 200,000 Oregonians on SNAP who are not on Medicaid. However, SNAP and MAGI have different household and incomes definitions, which Oregon is trying to reconcile.

Possible Savings Opportunities. In terms of potential savings for Oregon under the ACA, state officials believe that its 70,000 OHP Standard enrollees will be considered expansion enrollees under the ACA. OHP Standard Medicaid enrollees are noncategorically eligible adults with incomes below 100 percent of poverty for whom Oregon currently receives federal matching through its long-running Medicaid Section 1115 waiver. Officials believe that the OHP Standard benefit package does not meet the essential benefit package required by the ACA. If the state prevails, Oregon would receive a 100 percent federal match under the ACA for the group. Oregon does not have a medically needy program, so savings that could be gained by shifting medically needy beneficiaries to the HIX are not available to Oregon.

Officials note that Oregon does not have many remaining state-funded health programs, so they do not see significant savings opportunities by shifting existing programs, services or individuals in Medicaid to secure ACA funding. That said, the state has been discussing how some state dollars currently used to fund mental health services might eventually be rolled into CCOs, which would yield some savings. In addition, there is some potential interest in putting employment services and supportive services in CCOs, which also could generate savings for the state.

The Basic Health Program. Oregon officials have discussed the possibility of having a Basic Health Program (BHP), a new coverage option under the ACA for individuals with incomes between 139 and 200 percent

of poverty. The conversation is ongoing, and officials are well aware of the benefits BHP potentially affords enrollees, particularly for individuals who experience income fluctuations and are thus prone to churn on and off Medicaid. Further, having a BHP is consistent with the state's long-term notion that there be seamless eligibility between the HIX and Medicaid. At the same time, the state expressed concern about the affordability of the BHP and how such a program might affect the viability of the HIX, with the worry being that if covered lives are diverted to the BHP, fewer individuals would be in the HIX, which might affect premiums for remaining HIX enrollees.

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Medicaid Managed Care

Oregon has a long-running Medicaid managed care (MMC) program. At present, about 80 percent of OHP enrollees are in managed care. Oregon has physical MMC health plans that provide acute and ambulatory care services. Mental health, chemical dependency and dental services are carved out of the physical health plan but are paid on a capitated basis. In addition, in areas where there are not enough health plans, Oregon contracts with physicians, physician assistants and other like providers to serve as primary care case managers. When CCOs are launched, physical health and mental health will be combined into a single global payment; dental services are to be added in 2014.

Oregon does not have large, national health plans participating in its MMC program; instead, most OHP enrollees are in small, community-based "homegrown" health plans with a strong local flavor. Most of the MMC plans currently holding OHP contracts are nonprofit and offer only public-sponsored insurance; a few, however, have commercial business as well, including ODS Community Health, PacificSource and Providence Health Assurance, and Kaiser Foundation Health Plan. In the rural areas of the state, many of MMC plans are physician-owned and run.

Coordinated Care Organizations. Given the proposed move to CCOs in 2012, it is difficult at this juncture to assess MMC capacity under the ACA. At this time, what types of entities (health plans, hospitals, physician groups, counties) will emerge as CCOs is unclear. However, Oregon has plans to potentially have the CCOs bid to be an option for state employees, universities, teachers, and school districts. Together, about 850,000 individuals that are state-funded lives could be enrolled in CCOs, about one out of every four Oregonians. There is also the possibility that the CCOs could be an option under the exchange for small businesses. Thus, the potential scale of the CCO initiative makes it attractive to health plans and other health care stakeholders.

Although many of the details of the CCOs are still being developed, the vision is that CCOs will be community-based organizations that will bring together different health care providers. Moreover, which organizations will be CCOs will vary, according to officials. It was predicted that some of the current managed care plans will likely "morph" into CCOs. Hospitals were also mentioned as possible CCO candidates. Virtually all Medicaid enrollees will be in CCOs, including those dually enrolled in Medicare and Medicaid. While the criteria for a CCO are still in the works, one state official offered that one possible grouping could be a compact among a health plan, a hospital, the local county, and other health care providers that could come together and share risk. The state has made it clear that no entity, including managed care plans operating in Oregon today, could simply "flip a switch" and qualify as a CCO.

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CCOs will be responsible for the full array of services (physical, behavioral and dental). They will bear risk and receive a global payment, with the idea being that such a payment will afford CCOs the opportunity to organize and allocate resources differently. The global payments will be set based on revenue or expenditure targets and increased based on an agreed-upon rate, not historical

trends. Accountability is another major ingredient of CCOs. CCOs will operate under contracted benchmarks and performance standards that will include clinical, financial and operational metrics. The state is currently developing these metrics.

There are, however, several steps that the state must go through before CCOs become a reality. At present, state officials are setting out the details of CCOs, which will be documented in a report to the Oregon legislature in February 2012. If the legislature approves, the state will then move forward with submitting a Medicaid waiver application to the federal government, which must be granted before CCOs can be launched. Alignment with Medicare for those who are dually eligible is also under discussion with CMS through Oregon's Center for Innovation Duals Design cooperative agreement. At the time of the site visit in September 2011, Oregon officials had already held informal discussions with federal officials about the CCO concept.

Although provider industry groups were supportive of CCOs, they expressed some concerns. As one respondent noted, CCOs may "have the seeds of revolutionizing health downstream," but the state is banking on their producing significant savings in a year's time, which may be unrealistic. More fundamentally, they are concerned that not enough entities will sign up to be CCOs, particularly if the global payment is not set at a level that potential CCO participants view as appropriate. Further, the state must secure Medicaid waivers from the federal government in short order—waivers that the federal government "has not even conceived of" before.

Given the current state of flux of Oregon's MMC program, state officials are not actively working on making CCOs part of the HIX. Officials, however, do envision that in the future CCOs will participate in the HIX.

PROVIDER AND INSURANCE MARKETS

Oregon's health care market was described as being organized largely by geographic regions and populated primarily by locally owned and operated providers, not large national corporations. This is particularly true in the rural areas where more than 20 percent of Oregonians live. Indeed, because Oregon's health care market is organized at the local level and providers and health plans are largely "homegrown," state officials are optimistic that CCOs, which push responsibility for health care to the local level, will work. Believing that the more locally organized health care is, the easier it is to change patterns of care, Oregon officials are banking that CCOs will be able to realize substantial efficiencies and savings.

Health care providers and insurance firms were generally supportive of Oregon's health care efforts. While each group liked and disliked different elements of the reforms, the state appears to have successfully made the case to health care stakeholders that it cannot continue to finance the current health care system without changes. As Governor Kitzhaber put in spring 2011, for Oregon to get its costs under control, it must "innovate or die." And the industry has decided to innovate.

Hospitals

Oregon's acute care hospitals, described by some as the major player in the state's health care market, are overwhelmingly nonprofit institutions; only two of the 58 hospitals in the state are for-profit. Oregon has no publicly owned hospitals, and the vast majority of hospitals are independent institutions. Statewide, there is only one significant hospital system, Providence Health and Services, which has eight hospitals in Oregon.[41] The Portland metropolitan area was described as being a very competitive hospital market, whereas Eugene and Medford, the two other major urban areas, were described as being somewhat competitive. The rest of the state, largely rural, is almost exclusively served by sole hospital providers. According to respondents, significant hospital consolidation took place about 10 years ago, but the market has been fairly stable since that time.

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Like much of the rest of the country, a major change in Oregon's hospital market is the affiliation between hospitals and physicians. Described as the "number one

trend," estimates range as high as 50 percent of Oregon physicians who are now in a medical group owned by or aligned with a hospital. Because of this development, Oregon's health care system is increasingly characterized by highly integrated systems in which hospitals have the "whole burrito"—primary care, specialty care, health plan and the hospital all part of a single entity.

Informants described Oregon as having largely the same delivery systems for all populations, insured or otherwise. Thus, a safety net hospital system in the traditional sense does not really exist in the state. This is particularly true in rural parts of the state, where generally only a single hospital serves the local area. But even in the urban areas, respondents said that all hospitals take some uninsured and Medicaid patients. In the Portland area, by far the state's biggest metropolitan area, Emanuel Legacy Health and Oregon Health & Science University were described as the two major safety net providers. In 2010, disproportionate share hospitals, (DSH) payments accounted for only 1.3 percent of Oregon's Medicaid spending, making it a "low-DSH" state.[42] As such, the reduction in federal Medicaid DSH funding called for under the ACA has not been a major topic of debate in the state.

According to industry informants, Oregon hospitals overall are supportive of the state's health reform efforts, in large part because uncompensated care trends have been rising and hospitals recognize the need to get people covered. At the same time, there are many challenges ahead. On the one hand, more people will have insurance, but many of the preventive and efficiency efforts included in the ACA, as well as the state's vision for CCOs, will affect hospital revenues. In addition, as in many other states, Medicaid historically has not been a great payer in Oregon. So even though under reform more people will be covered, many will have Medicaid, which is worrisome to hospitals because of the program's low payment rates. Another issue brewing has to do with hospital provider taxes, on which, as described above, Oregon heavily relies to finance its Medicaid program. The direct benefit of the tax to hospitals potentially could be compromised if CCOs are successful in shifting care to more preventive and primary care, and away from hospitals. Such a shift could possibly jeopardize hospitals' willingness to continue paying the tax. State officials acknowledged that this is the "elephant in the room."

Primary Care Capacity

Given the large numbers of individuals who will gain coverage under the ACA, as well as the law's emphasis on preventive and primary care, whether there are sufficient numbers of primary care providers is a concern for all states. In Oregon there were mixed sentiments about whether primary care capacity was a problem. Virtually all respondents acknowledged that there was a shortage, particularly in rural areas. But some maintain that this assumes that care will continue to be delivered and organized as it is now. If CCOs are successful in streamlining and improving the efficiency of the health care system, some believe sufficient primary care capacity exists, especially if providers practice at the "top of their licenses."

In addition, Oregon's health reform legislation, HB 2009, called for the state to develop care attributes, measures, standards and incentives for care delivered by Patient-Centered Primary Care Homes (PCPCHs), which is Oregon's medical or health home model of care. Standards are now established and an outreach effort to certify medical practices is just underway. Oregon is also pursuing enhanced payment for Health Homes for Medicaid as provided for in the ACA. In yet another primary care effort, Oregon is working with insurers for state employees and school districts/teachers to encourage similar primary care incentive payments tied to the same standards as those of PCPCH. The aim of these initiatives is to encourage stability of primary care across the state and incent the new model of care to achieve enhanced care coordination, which Oregon believes is critical to a stable delivery system now, and to be prepared for upcoming coverage expansions called for under the ACA.

Oregon recently passed measures to help bolster the state's primary care capacity in rural areas, where capacity is more of a concern.

Finally, Oregon recently passed measures to help bolster the state's primary care capacity in rural areas, where capacity is more of a concern. (Some respondents considered urban areas as having sufficient primary care capacity to handle the coverage increases expected under reform.) These include a 2011 measure that established a loan forgiveness program for medical students who agree to practice primary care in rural areas of the state. Also in 2011, the Oregon legislature passed a bill tasking the OHA to develop a strategic plan for recruiting primary care physicians to the state, particularly rural areas.

Respondents noted that there has not been much growth in alternative types of care settings, such as urgent care centers. However, there has been some growth in physician extenders, such as physician assistants and nurse practitioners, who were described as having a broad scope of license in Oregon. Even so, respondents noted that the growth is not enough to meet the perceived need for primary care once the ACA is implemented.

Insurance Industry Competition and Response to Reform

As noted above, Oregon's commercial insurance market is relatively competitive compared to many other states. In the state's most recent analysis, the seven largest companies earned 92 percent of the $4.8 billion in premiums paid for major medical insurance. Two insurers are dominant: Regence BlueCross BlueShield, with 27 percent market share, and Kaiser Permanente, with 28 percent. Their next largest competitor, Providence, earned 11 percent.[43] State officials note that the plans compete "fiercely" for market share, and watch each other "like hawks." Most of the carriers are "domestic" (Oregon officials consider Kaiser a domestic carrier), and large national carriers have not gained much of a foothold. Some of our respondents noted that Oregon's competitive insurance market has placed carriers at a disadvantage relative to providers, many of which are hospital-based systems that carriers must include in their networks in order to remain competitive.

As noted above, the Oregon insurance industry has worked cooperatively with the state to implement the ACA. For example, while a number of insurance carriers threatened to leave the child-only insurance market in response to the ACA's requirement to guarantee policies to children under 19, officials applauded their willingness to work with the state to devise a reinsurance mechanism allowing them to stay in the market. The DOI has had few compliance problems with ACA implementation, and the carriers have put up little resistance to the DOI's efforts to enhance transparency. In addition, insurance industry representatives are participating actively in HIX planning efforts, and meet regularly with HIX staff to provide input and expertise.

Oregon's Business Community and the ACA

Both state and small business respondents noted that the Oregon business community has been generally supportive of health care reform. A representative of the governor's office noted that they had support "across the board" from the business community on implementation of the ACA. Similarly, the small business respondent noted that a number of small business leaders participated constructively in the debate over exchange legislation. And while many in the small business community had stood alongside consumer advocates in pushing an amendment to ensure that the exchange could negotiate rates with health plans, when the amendment was not adopted, they departed from their consumer counterparts and ultimately endorsed the bill. A number of small business representatives sit on an exchange advisory committee, and four of the nine members of the exchange board of directors represent small business interests. With the exception of the health sector, however, large employers in the state have been less active in health reform. Respondents speculate that those employers do not envision health care reform, particularly exchanges, having a dramatic impact on their business.

The small business respondent was extremely positive about health care reform, noting that he has personally benefited because he was able to put his 23- and 25-year-old children back onto his insurance. Also, as an employer who devotes 18 percent of his payroll to health coverage for his employees, he backs the law's requirement that employers contribute to health insurance, noting that he has higher costs than competitors that do not offer health benefits. He is also hoping the insurance exchange can provide small businesses with the "same negotiating power that large businesses have."

It appears that few small businesses are aware and taking advantage of the ACA's small business tax credits, which can cover up to 35 percent of health care costs for small businesses that pay at least 50 percent of their employees' health insurance premiums and have fewer than 25 full-time workers with average annual wages below $50,000.

Support for the law, however, is not universal within the business community. The state's chapter of the NFIB commissioned a survey of small business owners and concluded that many were "deeply uncertain and extremely suspect" over the ACA.[44] And the Oregon state director for the NFIB has called for the ACA to be "tossed out as unconstitutional."[45]

It appears that few small businesses are aware and taking advantage of the ACA's small business tax credits, which can cover up to 35 percent of health care costs for small businesses that pay at least 50 percent of their employees' health insurance premiums and have fewer than 25 full-time workers with average annual wages below $50,000.[46] The small business owner we interviewed is taking advantage of it, although he noted he was aware of the tax credits only because he had been so active on reform implementation. He has received no information or literature via the NFIB, the local chamber of commerce, his broker, or his accountant regarding the availability of the tax credits. He assumes other small business owners in the state have been left similarly in the dark.

CONCLUSIONS

Oregon has been working on health care reform for nearly 25 years, so it is not surprising that the state has made significant progress with strong bipartisan support in implementing ACA provisions. In many ways, the ACA simply provided the necessary resources and a clear timeline for Oregon to do many of the things it had been planning to do. Moreover, with the passage of CCOs, Oregon has taken the ACA a step further by tackling the health care cost issue directly. The CCO effort has support among Oregon political leaders and health care stakeholders, with both parties recognizing that the state needs to squarely address health care costs.

While Oregon has generally been a success story in its implementation of health care reform, the state faces challenges, as respondents readily acknowledged. One such challenge is that it now must take key pieces of its reforms from concepts to details—details that must be approved by the state legislature. Further, although health reform in Oregon has been bipartisan so far, it is not clear how the legislature will receive specifics, particularly heading into an election year.

Overlying the politics is Oregon's fiscal situation, which, like that of most states, was described as being between "terrible" and "awful." The concern is that if the state's economy declines further, it may take away from the state's momentum and focus on health care reform. But short of that, Oregon is well positioned to fully implement the ACA, as well as its own health care reforms by, January 1, 2014.

About the Authors and Acknowledgements

Teresa A. Coughlin is a senior fellow in the Urban Institute's Health Policy Center and Sabrina Corlette is a research professor at the Georgetown University Health Policy Institute-Center on Health Insurance Reforms. The authors thank the many Oregon government officials and health care stakeholders for their time and insights. This report would not have been possible without them. In particular, we are grateful for the contributions of staff from the governor's office, Department of Human Services, the Oregon Health Authority, the Department of Insurance, and the Oregon Health Insurance Exchange Corporation. Finally, a thank you is extended to Linda Blumberg, John Holahan, and Shanna Rifkin for their comments and input to the study and the report.

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The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace.

NOTES

1 For Oregon, a three-person team conducted a three-day site visit September 27 -29, 2011. A total of 18 key informant interviews were conducted. Most interviews were done in person, but some were completed by phone. Interviews were conducted with state officials from the Governor's Office, Department of Human Services, the Oregon Health Authority, the Department of Insurance, and the Oregon Health Insurance Exchange Corporation; representatives from professional health care associations; a managed care health plan; and other stakeholders. Using a broad semi-structured interview guide, interviews covered the same general topics – Health Insurance Exchange establishment, private health insurance market reforms, Medicaid, and the health care delivery system (including managed care). Transcripts and notes from the interviews were analyzed to produce this report. In addition, a review of the published and gray literatures and documents obtained on site supplemented the interviews.

2 This includes an estimated 560,000 Medicaid enrollees, 360,000 individuals in the commercial market, and 98,000 small business workers expected to use the HIX. Oregon Health Insurance Exchange Establishment Grant Narrative, http://www.oregon.gov/OHA/docs/heix-planning-grant-narr.pdf?ga=t.

3 For more background information on Oregon's reform efforts, see Oregon Department of Health Services, *Oregon Health Plan: An historical overview* (Health Services, Office of Medical Assistance Programs, July 2006); L. D. Brown, "The National Politics of Oregon's Rationing Plan," *Health Affairs* 10(2) (1991):28–51.

4 Oregon Department of Consumer and Business Services, *Health Insurance in Oregon*, (January 2011).

5 This was in addition to passing legislation creating the HIX corporation.

6 Numbers in this paragraph are from the Urban Institute's Health Insurance Policy Simulation Model or HIPSM.

7 *Ibid.*

8 2011 Ore. SB 99 (2011).

9 Established in 2004, the Oregon Health Policy Commission served as the state's policymaking body tasked with health policy and planning.

10 See https://orhix.org/.

11 *Ibid.*

12 Oregon Exchange Work Plan, presented at Oct. 6, 2011, board of directors meeting, available at http://www.oregon.gov/OHA/docs/2011-1006-hix-wk-plan.pdf.

13 *Ibid.*

14 *Ibid*.

15 "Defined contribution" plans allow employers to fix their costs on a monthly basis by making a defined contribution to an employee's coverage, as opposed to paying the costs to provide a specific group health plan benefit (a "defined benefit" plan). Oregon is considering this model as a way to facilitate employee choice. See Oregon Health Exchange Corporation Business Plan (draft), available at https://orhix.org/uploads/orhix_business_plan.pdf.

16 *Ibid.*

17 The Lund Report, "Senate Confirms Governor's Nominees to Insurance Exchange Board," Sept. 22, 2011, available at http://www.lundreport.org/resource/senate_confirms_governors_nominees_to_the_insurance_exchange_board.

18 Oregon Health Authority, Health Insurance Exchange Consumer Advisory Committee, available at http://www.oregon.gov/OHA/hiex-con-ag.shtml.

19 Oregon Exchange Work Plan.

20 *Ibid.*

21 ACA, § 1311(i)(6).

22 76 Fed. Reg. 41866, 41917 (July 15, 2011).

23 ACA, § 1002, adding new Public Health Service Act § 2793.

24 2011 Ore. SB 89 (2011).

25 A "grandfathered" plan is one in existence as of the date of the ACA's enactment, March 23, 2010. Grandfathered plans are exempt from some, but not all, of the ACA's early market reforms. ACA § 1251.

26 75 Fed. Reg. 37188, 37235 (June 28, 2010).

27 2011 Ore. SB 514 (2011).

28 Memorandum to Individual Market Carriers relating to Children's Reinsurance Pool, available at http://www.oregon.gov/OHA/OPHP/OMIP/docs/reinsurance_pool_memo.pdf.

29 OMIP "Stat Pack," July 2011, available at http://www.oregon.gov/OHA/OPHP/OMIP/docs/omip_stat_pack.pdf; FMIP "Stat Pack," July 2011, available at http://www.oregon.gov/OHA/OPHP/OMIP/docs/fmip_stat_pack.pdf.

30 Department of Consumer & Business Services, "Health Insurance in Oregon: January 2011," available at http://insurance.oregon.gov/health_report/3458-health_report-2011.pdf.

31 See, for example, Statement of Teresa Miller, Administrator of Oregon's Insurance Division, to U.S. Senate Committee on Health, Education, Labor & Pensions, Hearing on the Impact of Rate Review, Aug. 2, 2011, available at http://help.senate.gov/imo/media/doc/Miller6.pdf; "Oregon Insurance Commissioner Receives Consumer Award," Nov. 3, 2011, available at http://insurance.oregon.gov/news_releases/2011/110311-millerconsumeraward.pdf.

32 Ore. Rev. Stat. § 743.018.

33 Ore. Rev. Stat. § 743.734.

34 Center for Consumer Information and Insurance Oversight, "Health Insurance Rate Review: Lowering Costs for American Consumers and Businesses," Fact Sheet, available at http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.

35 Bill Graves, "22 percent rate increase by Regence BlueCross BlueShield of Oregon Brings Out Strong Protest," *The Oregonian*, June 2, 2011, available at http://www.oregonlive.com/health/index.ssf/2011/06/22_percent_rate_increase_by_re.html.

36 http://www.oregonhealthrates.org/?pg=premium.html.

37 Oregon Division of Insurance, Health Insurance Rate Review Grant Program: Cycle I, Quarter 3 Grant Report, available at http://insurance.oregon.gov/consumer/federal-health-reform/ratereviewgrant-report-C1Q3.pdf.

38 ORS § 743.018.

39 Department of Consumer & Business Services, "Health Insurance in Oregon: January 2011."

40 In addition, the Healthy Kids initiative allowed children in families between 200 and 300 percent of FPL to buy private insurance through an exchange called Healthy Kids Connect with the help of a premium subsidy; children in families above 300 percent of FPL could buy insurance through the exchange at full cost.

41 While the Kaiser Foundation Health Plan operates in Oregon, stakeholders perceive it to operate as an independent health plan.

42 Urban Institute estimates based on CMS-64.

43 *Op. Cit.,* "Health Insurance in Oregon."

44 NFIB/Oregon, "Oregon Poll Puts Finger on the Pulse of the Problem With ObamaCare," Mar. 7, 2011, available at http://www.nfib.com/oregon/nfib-in-my-state-content?cmsid=56243.

45 *Ibid.*

46 ACA § 1421.cou.