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OREGON: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

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OREGON: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

Talk of implementing a health insurance exchange in Oregon predates the passage of the Affordable Care Act (ACA). Oregon policymakers, administrators, and other interested parties were discussing a health insurance exchange beginning in 2004.[1] Initiated by then-Governor Ted Kulongoski, the Oregon Health Policy Commission developed recommendations for health care delivery reform, which included discussion of access and coverage, but also a recommendation for a health insurance exchange.

While there was broad political support for an exchange, as well as support among individuals and small businesses, the state lacked the funds to move forward with such an effort. The Oregon Health Policy Commission refined these recommendations in 2005. In 2007, Oregon SB 329 created a new entity, the Oregon Health Fund Board, to take these recommendations and begin to facilitate state-based health reform in earnest.

Specifically, the members of the Health Fund Board were tasked with developing recommendations to help ensure access to health care for all Oregonians, to lower health care costs, and to refine health care delivery. These efforts were supported by Oregon HB 2009, which was passed in 2009 and set out a number of tasks related to health care reform. These include reorganizing Oregon's health-related agencies into the Oregon Health Authority, creating the Patient-Centered Primary Care Home program (see

Section 1.2), and directing the Oregon Health Policy Board (the governing body of the Oregon Health Authority) to create a business plan for a proposed health insurance exchange. But once again, any effort to move forward was stymied by funding issues. Only with the passage of the ACA did Oregon have the financial resources to do anything with the plans it had spent years creating. However, with the groundwork having been laid for developing a health insurance exchange over a number of years, many feel passing legislation to actually create and implement an exchange in Oregon was made easier.

The legislation that would ultimately create Oregon's exchange was crafted primarily through a series of meetings and discussions among representatives of the state, the small business community, and insurance carriers. Key players from the state included individuals who would ultimately become part of the leadership team of the exchange — Rocky King, Nora Leibowitz, and Amy Fauver — as well as Mike Bonetto and Sean Kolmer, who are key health policy advisors to Governor John Kitzhaber, and Barney Speight, director of the Oregon Health Fund Board. From the business community, Duncan Wyse, president of the Oregon Business Council, Ryan Deckert, president of the Oregon Business Association, and Betsy Earls, who oversees the policy efforts of Associated Oregon Industries, are widely seen to have been key players in the legislative process surrounding the health exchange. Tom Holt, director of Legislative and Regulatory Affairs for Regence BlueCross BlueShield, played an integral role in representing the interests of local insurance carriers. In addition, members of the Oregon Senate health subcommittee, which oversaw the crafting of Oregon SB 99, including Democrat Laurie Monnes-Anderson and Republican Frank Morse, were integral in engendering bipartisan support for the proposed exchange.

Oregon SB 99 established the Oregon Health Insurance Exchange Corporation as a quasigovernmental organization. Kitzhaber — a former emergency room doctor and a strong, vocal proponent of health care reform — signed it into law on June 17, 2011.[2] Also in June 2011, Kitzhaber signed SB 91.[3] This law specifies what is required of health insurance carriers that offer coverage in Oregon. This does not mean the path was fully cleared for establishment of the exchange, however. Conservative members of the Oregon legislature insisted that the exchange be soundly planned and executed with a business plan. The final version of the exchange's business plan was approved by the state legislature in March 2012.[4] Later that year, it was announced that the official name of the exchange would be Cover Oregon.

Oregon applied for and received two federal grants — one received in 2012 and the other in early 2013 — to fund the development of Cover Oregon.[5] The first grant, which provided $6.6 million, helped Cover Oregon hire staff, pay for administrative costs, and contract with a local vendor to prepare the individual and Small Business Health Option Program (SHOP) user

interfaces, all of which helped it prepare for federal certification in 2013. The second grant, for more than $226 million, will provide funding for Cover Oregon's expenses through 2014 in order to make it fully operational. Oregon also negotiated a Section 1115 Medicaid Demonstration Waiver with the Centers for Medicare & Medicaid Services (CMS) that will provide $1.9 billion over five years to aid in the development and implementation of Coordinated Care Organizations (CCOs). Although this money does not directly support implementation of Cover Oregon, it does support development of the necessary infrastructure and integration of health service delivery processes as part of broader system transformation.

All laws concerning the development and implementation of a health insurance exchange in Oregon drew bipartisan support and passed with seemingly little controversy. Still, a number of issues stirred debate.[6] First, a few conservative legislators felt that any health insurance exchange legislation would be associated with "Obamacare" and wanted nothing to do with it. This sentiment was reinforced by a sense that if lawmakers did nothing on health reform, Oregon would be subject to the federal health insurance exchange without any recourse. This did not jibe with Oregon's independent spirit and desire to control its own destiny.

Second, controversy arose along party lines over whether to allow insurance brokers to be involved with the exchange. A number of Democratic legislators argued that brokers added no value to the process and should be excluded from it entirely. Republican legislators, with whom the broker community has stronger ties, resisted this view and argued that brokers should be included in the process. Ultimately, negotiations led to the inclusion of brokers in the exchange, with their commissions embedded in the premium.

Finally and most importantly, consumer and labor groups actively lobbied the legislature to have the exchange be an "active purchaser," a model through which the state would be empowered to selectively contract with carriers, potentially set tougher participation criteria than the federal standards, and/or negotiate price discounts in order to effectively serve consumers.[7] These groups included the Oregon State Public Interest Research Group, AARP Oregon, and the Service Employees International Union,[8] all of which voiced their opinions during extensive public hearings on SB 99. Their efforts were strongly supported by a Democratic contingent of legislators led by Rep. Mitch Greenlick. This coalition was ultimately unsuccessful, though, primarily because conservative members of an evenly split Oregon House of Representatives — led by Jim Thompson — did not support this model (neither was it supported by the businesses community or insurance carriers) and their votes were necessary for passage of legislation on the exchange. In other words, the model that Cover Oregon adopted — a clearinghouse model that is open to all qualified insurers — is viewed as something of a compromise between

the state and some Democratic leaders and business interests, insurance carriers, and their Republican allies in the Oregon legislature.

1.2. Goal Alignment

Oregon has taken an overwhelmingly affirmative response to the ACA, as evidenced by its enthusiastic development and implementation of Cover Oregon and its decision to expand Medicaid. In fact, it is one of six states to receive a Model Testing award from the Centers for Medicare & Medicaid Services,[9] which will support continuing efforts to transform its health care delivery system through innovative methods. Chief among these innovative efforts is the implementation of CCOs, which were codified into law with the passage of Oregon HB 3650.

Oregon developed CCOs in an effort to accommodate the increased enrollment into Medicaid afforded by the ACA. CCOs are community-based networks of providers, community programs, and insurers that provide coverage and health care for people who are eligible for Medicaid through the Oregon Health Plan (OHP) and which operate within a capitated global budget. Because the budget grows at a fixed rate, CCOs assume financial responsibility and risk for the health-related costs of their enrolled populations.[10] While they vary substantially in their organizational structure, all serve as "umbrella" organizations that provide physical, addiction, mental, dental, and other health-related services to OHP beneficiaries. The intention of the CCOs is to provide greater public and individual health care through the achievement of the "triple aim" of lower costs, better health care delivery, and overall better health for Oregonians. The Oregon Health Authority (OHA) is the local regulatory agency that oversees the OHP and all of the CCOs, of which there are currently fifteen throughout the state.

While some controversy accompanied passage of SB 99 and the implementation of a health insurance exchange, there were few[11] concerns and doubts about HB 3650—the transformation of Oregon's health care delivery system through Coordinated Care Organizations, and the objective of this new model to achieve the "triple aim."[12] Indeed, the legislation had a number of conservative backers, including Representative Tim Freeman, who championed it because they saw the benefit of controlling health reform efforts at the local level.

Oregon also established the Patient Centered Primary Care Home (PCPCH) program through Oregon HB 2009 to support the "triple aim." Elsewhere called the Primary Medical Home model, the PCPCH seeks to achieve the "triple aim" by emphasizing "wellness and prevention, coordination of care, active management and support of individuals with special health care needs, and a patient and family-centered approach to all aspects of care."[13] The program seeks to identify practices and clinics that can be designated as PCPCHs, to encourage practices and clinics

to adopt the PCPCH model, and to encourage participants in the OHP to receive care with designated PCPCH practices and clinics.[14]

While the establishment of the PCPCH program predates passage of the ACA (Oregon HB 2009 was signed into law in 2009), the ACA contains numerous provisions that encourage adoption of this model of care. Indeed, the ACA provides for a number of financial incentives, namely reimbursement rates, which encourage the adoption of the primary medical home model.[15]

Part 2 – Implementation Tasks

2.1. Exchange Priorities

The main priority for Cover Oregon is its Web site. Indeed, it is central to its operation, as it serves as the portal by which both individuals and small businesses can compare and enroll in coverage (both commercial and Medicaid), and access financial assistance to do so. Development, implementation, and maintenance of its information systems capabilities are also high priorities for Cover Oregon.

As a recipient of an Early Innovator Grant, Oregon has been able to draw on significant funds to develop and support the information technology infrastructure necessary for the single Web portal that underpins its exchange. Cover Oregon utilized commercial, off-the-shelf products (e.g., Oracle software) rather than build new systems.[16] In 2012, the staff of Cover Oregon purchased, installed, and began developing the technical and operational requirements to build the Cover Oregon Web site.[17] They also participated in and passed federal "gate" reviews[18] with the Center for Consumer Information and Insurance Oversight, and built security measures for information technology (IT) systems. Finally, they developed, tested, and began implementing the multiple interfaces for individual consumers and small businesses for the billing system, and for the tribal option, through which recognized Oregon tribes have the option to purchase premiums for tribal members, employees, and other members of their communities.[19] In addition, Oregon was among eleven states that participated in the Enroll UX 2014 project, a public-private partnership involving national and state health care foundations and the federal government, and helped to develop design standards for health insurance exchanges to provide ease of access for consumers.[20]

Despite all these efforts, the Web site was not fully operational on the October 1st "go live" date, and at the date of the writing of this report (November 25, 2013) was still not up and running. Cover Oregon has asked program agents to discontinue scheduling appointments with clients until further notice,[21] and has begun processing more than 17,000 paper applications by hand, vowing to enroll all Oregonians who want coverage starting January 1, 2014.[22]

This is not a surprise to some observers. The substantial funding that Oregon received for Cover Oregon (see Section 1.1) may have led to an overly ambitious vision for the Web site in a short development and implementation timeframe. While many support the overall aims of Cover Oregon, some observers raised concerns that Cover Oregon may have tried to accomplish too much in too little time. In other words, they feel Cover Oregon may have tried to build an overly complicated "do it all" system, rather than prioritize basic functionality and draw on existing technology and systems used successfully in the private sector (e.g., creating new provider directories rather than utilizing carriers' existing directories or even existing software designed for this purpose). Decisions related to the Cover Oregon Web site and its resulting complexity may reflect a legacy of a disjointed and imperfect effort to revolutionize Oregon's use of health information technology.

2.2. Leadership – Who Governs?

The leadership of Cover Oregon includes an oversight Board and an executive team led by Executive Director Howard "Rocky" King. The team is rounded out by four individuals who oversee operations, communications and marketing, policy development and implementation, and information technology.

Kitzhaber named King interim director in June 2011 and as its permanent director in October 2011. King has an extensive background in both government and insurance administration. He has been the director of health care purchasing for the Oregon Health Authority, administrator of the Office of Private Health Partnerships (OPHP), and the Oregon Medical Insurance Pool (OMIP), and helped create the Senior Health Insurance Benefit Assistance Program (SHIBA).[23] In December 2013, however, King was placed on an extended medical leave, with Bruce Goldberg stepping in as the acting director of the exchange.

The nine-member Board (excluding the ex officio members) was appointed by Kitzhaber and approved by the Oregon State Senate. SB 99, which established Cover Oregon, also set the criteria for Board appointments. Board members must be U.S. citizens; have demonstrated professional and community leadership; represent the geographic, ethnic, gender, racial, and economic diversity of the state; and offer expertise in the following areas: individual insurance purchasing, business, finance, sales, health benefits administration, individual and group health insurance, and the use of a health insurance exchange. In addition, at least two members must be consumers — one individual consumer and one small business owner who purchases coverage through Cover Oregon. At present, the Oversight Board is constituted of the following members:

- Chair: Liz Baxter, executive director, Oregon Public Health Institute
- Vice Chair: Teri Andrews, owner, CG Industries

- Ken Allen, executive director, Oregon AFSCME Council 75
- Dr. George Brown, CEO, Legacy Health System
- Aelea Christofferson, owner, ATL Communications
- Dr. Bruce Goldberg, director, Oregon Health Authority
- Jose Gonzalez, principal broker, Tu Casa Real Estate Corporation
- Gretchen Peterson, vice president of human resources, Hanna Andersson
- Laura Cali, insurance commissioner, Insurance Division, Oregon Department of Consumer and Business Services[24]

Bruce Goldberg and Laura Cali are ex officio members of the Board.

2.3. Staffing

At the end of 2012, Cover Oregon had forty-five employees, but expected to employ approximately 185 full-time employees and 100 temporary customer service workers by the time the exchange went live in October 2013.[25] Of the 185 full-time employees, sixty-five are to be focused on operations, IT, customer service and training, communications, outreach, marketing, financial management, and research and evaluation.[26] In addition, Cover Oregon was to contract out to vendors a number of specialized services, such as risk assessment, quality assurance development, IT, marketing, and project management.[27] We have not been able to confirm the size of the workforce, nor the specific allocations of duties. What can be confirmed, however, is that in early November 2013 Kitzhaber authorized the hiring of 400 additional temporary workers to process paper applications of individuals applying for coverage while the Cover Oregon Web site remained offline.[28]

2.4. Outreach and Consumer Education

Cover Oregon utilizes a multifaceted approach to reach out to consumers and to encourage participation in the exchange. First, it partnered with the Oregon Health Authority to administer a community partner program to provide education and outreach to consumers and help them enroll in the plans offered through Cover Oregon.[29] Community organizations become partners through a grant application process, although it appears that the majority of partners had already played advisory roles for clients interested in enrolling in the Oregon Health Plan and/or Healthy Kids.

In addition, Cover Oregon developed a Tribal Technical Workgroup to receive meaningful input from the nine federally recognized tribes in Oregon.[30] This workgroup includes representatives from the nine tribes, the Northwest Portland Area Indian Health Board, and Cover Oregon staff. The goal of the workgroup is to ensure that all benefits and protections afforded by the ACA

are brought to bear for the tribes. Cover Oregon has also contracted with the Northwest Portland Area Indian Health Board to conduct research into health insurance issues that directly affect the tribes.

Finally, Cover Oregon contracted with NORTH, a Portland-based advertising and marketing agency. NORTH, in partnership with the public affairs agency Metropolitan Group, has developed and implemented a wide range of marketing and advertising efforts.[31] Web-based, television, and radio commercials for Cover Oregon began airing in July 2013, and have been noted for their resemblance to a buoyant tourism campaign.[32] They feature Oregon-based musicians singing anthemic songs about keeping Oregon healthy, as well as arresting images associated with Oregon developed by local visual artists.

All of these efforts seem to have paid off, although perhaps paradoxically. Cover Oregon has strong name recognition, so much so that on October 1st, the Cover Oregon Web site logged approximately 10,000 hits. This level of activity caused the site to crash.

2.5. Navigational Assistance

Cover Oregon operates a fully staffed call center in Salem to answer consumers' questions about enrollment and eligibility, along with general questions about health reform.[33] In addition, Cover Oregon has trained licensed health insurance agents to help traditionally hard-to-reach populations understand their options and enroll in coverage.[34] Finally, while the use of brokers was a contentious issue during the legislative debate over Cover Oregon (see Section 1.1), it appears that they are playing a vital role in helping individuals navigate the options available through the Exchange, especially while the Web site remains offline and while Cover Oregon navigational agents are being asked to discontinue their work until further notice.

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs): Cover Oregon offers twelve medical insurance carriers, all of which are required to offer three metal-level plans (bronze, silver and gold) at both the individual and small business levels, as well as child-only plans at all metal levels.[35] In addition, the carriers have the option to offer nonstandard plans; additional plans that demonstrate some level of innovation in health management (e.g., use of networks, wellness plans, etc.); platinum plans; and catastrophic plans.[36] We have not been able to confirm whether or how many carriers offer these optional plans. Cover Oregon also offers eleven dental carriers, some of which are also medical carriers. Individuals in Oregon are not required to purchase a dental plan, however.

2.7(b) Clearinghouse or Active Purchaser Exchange: Cover Oregon is a clearinghouse form of exchange. (See Section 1.1 for a

discussion of the decision-making process regarding the selection of this model of exchange.)

2.7(c) Program Articulation: Cover Oregon's application process allows for immediate connection of low- to moderate-income applicants to appropriate programs (e.g., the Oregon Health Plan, Healthy Kids, etc.) and to financial assistance options.

2.7(e) Government and Markets: While Oregon does not yet have a private health insurance exchange to compete with Cover Oregon, there has been discussion as to whether Cambia Health Solutions, a holding company that counts Regence BlueCross BlueShield of Oregon as one of its companies, is looking to do so.

2.8. Data Systems and Reporting

In spring 2011, OHA convened a meeting of health system researchers to discuss the evaluation of Oregon's health care transformation. As part of this effort, Oregon planned to conduct a phased, multilevel evaluation corresponding to the three grant periods associated with the receipt of federal funding for the health insurance exchange. The initial phase was comprised of 1) focus groups to establish a baseline for consumers' understanding about health insurance choices and their expectations for learning about health insurance, applying for coverage, and enrollment; 2) a small employer survey to establish a baseline of the status of insurance coverage for small employers (one to fifty workers); and 3) an online survey to collect stakeholder feedback on exchange development efforts. The overall evaluation mirrored the 2011-12 work plan that was submitted with the federal grant application, and described milestones, key indicators, and measures associated with the development and implementation of the exchange, including the development of data systems. Specific activity measures that were not met would prompt exchange staff to determine what the barriers to completion were, revise the timeline, assess the impact on other parts of the work plan, and determine whether interventions were required. Evaluation findings are reported quarterly to the exchange's executive director and Board, and incorporated into quarterly progress reports.[37]

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Cover Oregon — working with business groups throughout 2012 — has developed four options for private firms that employ fifty or fewer individuals. These options include a traditional plan in which the employer chooses one insurer and plan and all employees must enroll in it; plan bundling by which the employer chooses one insurer but allows employees to choose their own plan; the multiple companies/one plan option by which the employer selects a benefit plan level and employees can choose a plan from all insurers; and the broad choice option in which

employees of a small employer are able to select from several insurers and plans.[38]

Part 4 – Summary Analysis

4.1 Policy Implications

The implementation of Oregon's health insurance marketplace is likely to benefit several groups — both expected and unexpected. Among the expected beneficiaries are persons who previously lacked access to affordable health insurance or experienced other barriers to coverage; chiefly those persons who were previously denied insurance because of a pre-existing health condition. As of October 31, 2013, more than 17,000 people had applied for coverage through either the electronic or paper-based systems.[39]

In addition to enrollment in an exchange-based insurance product, many residents were deemed eligible for Medicaid and now receive benefits through the Oregon Health Plan. Benefits may also accrue to health services providers as more patients will have insurance coverage. However, physician concerns that they will be paid less for care provided to persons with insurance purchased through the exchange marketplaces have been noted in other states,[40] while the greater concern among Oregon doctors is the as-yet undetermined arrangements that shift financial risk for expensive care from health plans to providers.[41] It is unclear if these issues will precipitate action by doctors, or what form such actions might take.

Similarly, risk-sharing arrangements between health plans and hospitals (or health care systems) have been a point of discussion, but specific arrangements that could result in shifting of alliances and alignment of interests have yet to be defined. The ongoing implementation of Oregon's CCOs suggest that collaboration, efforts to negotiate risk-sharing arrangements, and greater integration will create "win-win-win" situations among health plans, CCOs, hospitals, and other health service providers. However, relative to the realignment of interests stemming from the creation of CCOs, the health insurance exchange marketplace appears to have had less of an impact on health policymaking activities and institutional affiliations.

The health insurance industry may also benefit from health reform. During the design and early implementation phases of Cover Oregon, health plans, benefits consultants, and insurance brokers were apprehensive about the impact of health reform on risk selection and premiums in the nongroup and small-group markets.[42] Although brokers historically dominated the non- and small-group markets and were a substantial political force, concerns about their ongoing role motivated health insurance brokers to lobby key legislators. Their efforts ensured the inclusion of brokers' commissions in insurance premiums, and assured their continuation as central players in the marketplace. Given the subsequent challenges with Cover Oregon's online enrollment

process, brokers have proven to be an important resource, particularly for the small business community.

Direct and indirect benefits have also accrued to thirty nonprofit, community-based organizations that received one-year grants totaling $3.16 million.[43] The grants support on-the-ground outreach and enrollment efforts. The funding also furthers the broader missions of the recipient organizations, all of which serve diverse, remote, vulnerable, and underserved populations. Many business associations benefitted from similar grants, receiving more than $600,000 to help small businesses and their employees find the health insurance option that best meets their needs and to determine eligibility for tax credit subsidies.[44] A final indirect beneficiary of health insurance exchange implementation is the advertising industry. Like many states, Oregon invested substantially in marketing efforts to further outreach and enrollment. The first phase of Oregon's advertising campaign totaled approximately $3.2 million.[45]

4.2. Possible Management Changes and Their Policy Consequences

The most immediate management challenge Oregon faces is the nonfunctional Cover Oregon Web site and online enrollment features of the exchange. Citing basic problems with a contract based on time and materials rather than fixed-price deliverables, Cover Oregon officials note that the current contract is part of a much larger OHA IT modernization effort.[46] Although the online system experienced substantial delays, the state demonstrated its ability to develop and implement temporary solutions and moved fairly quickly to a paper-based application process.

A more important consideration is the ability of the state, and OHA in particular, to implement multiple health system transformation initiatives simultaneously. The Web site issue is a prime example of the challenge Oregon faces in those efforts. Locating all health and health service purchasing for the state in one agency may generate greater efficiency, coordination, and integration of administrative functions. However, it may also create a level of complexity and bureaucracy that hinders specific initiatives. Developing health policies that facilitate the integration of administrative functions, alignment of financial incentives, and coordination of health care services has proven to be a vexing problem for each of these singular goals. Even in Oregon's mature and relatively collaborative health services market, integrating these elements across public and commercial health insurance markets will require substantial, ongoing focus and fiscal support. Management decisions that are driven by the short-term accountability metrics associated with current grants and federal waivers may undermine the longer-term goals of system transformation.

Given the state's culture and history of bipartisan support for health system reform, the most substantive changes are likely to be seen at the level of health care delivery. Evidence of changes in

management systems to address transformation goals are taking shape in the form of Oregon's CCO governance structures; negotiations to address risk-sharing among CCOs, hospitals, and specialty and primary care physicians; a renewed focus on integration and coordination of care; and more explicit recognition of the role of social and environmental determinants of health. Implementation of Cover Oregon is but one dimension of health system transformation.

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