



# A Better Health Insurance Market for Oregon

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Options for Oregon to Maintain Consumer Access  
to Affordable Health Insurance

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# | Executive Summary

**THE RISING COST** of health care is driving up the cost of insurance for all consumers, especially for those who buy insurance through the individual market. The federal Affordable Care Act (ACA) included measures to create a stable insurance market where individual consumers could obtain affordable, comprehensive insurance. However, as the federal government has lessened its support of the health care law, the market for individual insurance has weakened, limiting consumers' ability to obtain comprehensive insurance at a reasonable price.

Oregon can adopt a number of policies to help stabilize the individual insurance market, which is important for those who currently buy insurance there and those who might need to do so in the future. Oregon can stabilize the market by reducing uncertainty and risk for insurers and encouraging healthier consumers to continue to buy insurance coverage. To achieve long-term stability for all consumers, however, Oregon must also pursue options for reducing the high cost of health care.

Health care is expensive, with prices rising annually. This means that insurance is also growing more expensive.

- In 2014, \$31.9 billion was spent on health care in Oregon, an average of \$8,000 per person.<sup>1</sup> Since then, national-level data show that expenditures increased by 5.9 and 4.3

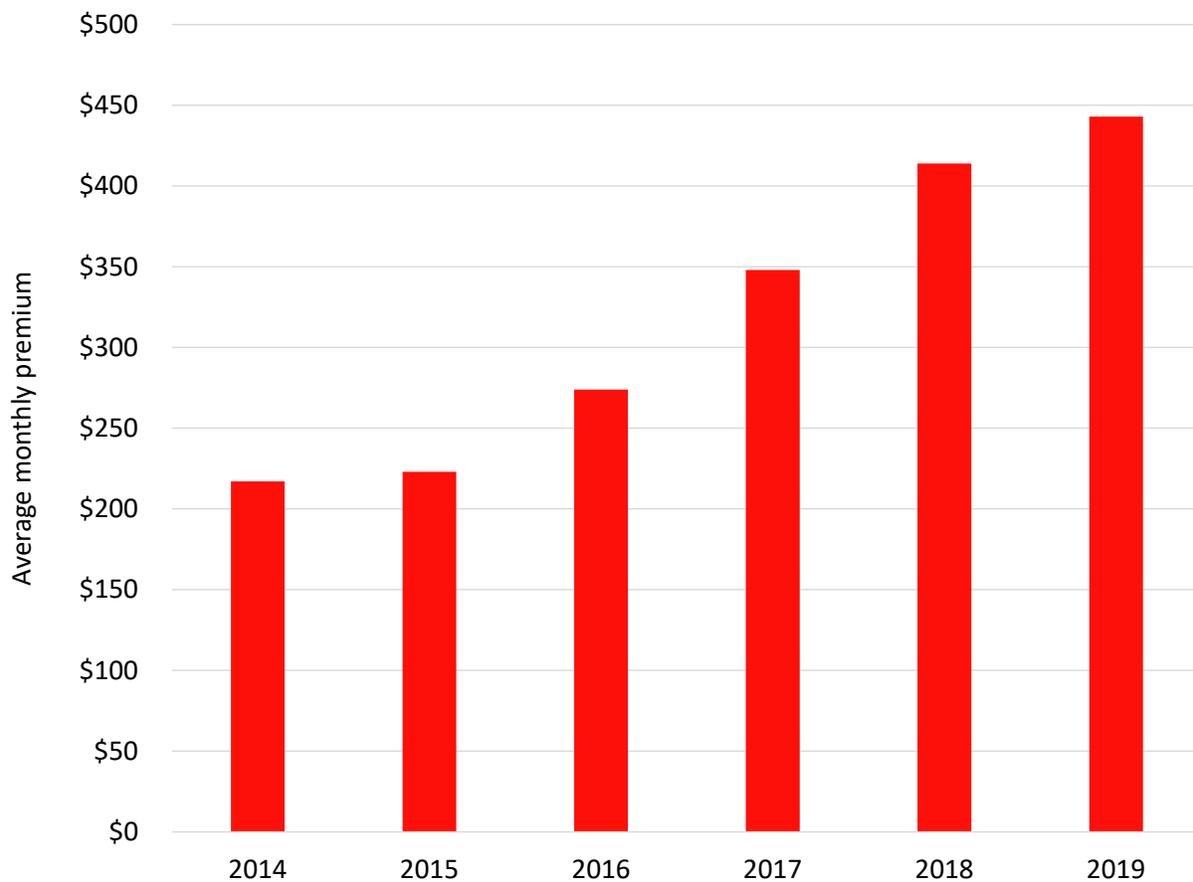
percent in 2015 and 2016, respectively.<sup>2</sup>

- Oregonians who buy insurance for themselves and their families without the help of an employer or public program face high and rising costs. The average monthly premium for the second-cheapest "silver" level plan in Oregon's individual marketplace is \$443 in 2019, nearly double what it was in 2014 (see Figure ES-1).<sup>3</sup>

The ACA sought to address multiple problems with health care, including by creating a marketplace where individuals could purchase comprehensive insurance at a reasonable price. (See "How the Individual Online Marketplaces Work.") Recent federal policy changes, some planned in the ACA and some unexpected decisions by Congress and the Trump administration, coupled with continually rising health care costs, have begun to undermine the individual insurance market. That means it will be more difficult for individual consumers to obtain affordable, comprehensive health insurance coverage.

- After multiple unsuccessful attempts to repeal the ACA, Congress instead eliminated the penalty that enforced the individual mandate that individuals have health insurance.<sup>9</sup> Multiple insurers in Oregon cited the loss of the individual mandate as a factor in why they proposed higher rates in 2019.<sup>10</sup>

FIGURE ES-1. THE MONTHLY COST OF THE SECOND-CHEAPEST SILVER-LEVEL INDIVIDUAL PLAN IN OREGON NEARLY DOUBLED FROM 2014 TO 2019<sup>4</sup>



## HOW THE INDIVIDUAL ONLINE MARKETPLACES WORK

THE AFFORDABLE CARE ACT implemented online marketplaces, or “exchanges,” where individuals who need to buy insurance for themselves can shop for and purchase health insurance. The federal government provides advance tax credits to eligible customers on the exchange to offset the cost of their monthly premiums.<sup>5</sup> On the exchange, insurers decide county-by-county what types of coverage to sell. Plans are grouped by the generosity of the coverage into bronze, silver, gold and platinum categories.<sup>6</sup> The amount of the tax credit that helps consumers with their insurance premiums is tied to the cost of plans in the silver category, which balance moderate premiums with moderate coverage.<sup>7</sup> Specifically, the silver plan with the second-lowest premium available to the individual is the benchmark plan for purposes of the tax credit.<sup>8</sup>

- Several federal risk-reduction programs that helped protect insurers from unexpectedly high costs have ended, potentially exposing insurers to greater expenses and greater uncertainty. Three insurers who had participated in Oregon’s individual insurance market in the first several years of the ACA ended or scaled back their offerings after the federal government withdrew promised financial support for insurers.<sup>11</sup>
- Insurers no longer receive a cost-sharing subsidy for providing plans to lower income customers, but still must sell those plans. Through an approach called “silver loading,” insurers have increased premiums on other customers to cover their costs, meaning that thousands of Oregon customers who do not qualify for tax credits to offset higher premiums are now paying more for insurance.<sup>12</sup>
- The federal government has eased rules on health plans that do not comply with ACA requirements. This allows insurers to sell plans with less comprehensive coverage.<sup>13</sup> Oregon has imposed significant restrictions on such plans that may curtail their impact in the state, though such plans are still available.<sup>14</sup>

These forces have begun to destabilize the market for individual health insurance by adding uncertainty and risk for insurers who sell health insurance plans to individuals, driving up insurance premiums and potentially reducing the pool of healthy people purchasing insurance. As healthy people leave the insurance market, only sicker patients remain. This means insurers have higher average

health care costs per customer, which leads to higher premiums and further discourages healthy people from purchasing insurance. This market dynamic is sometimes referred to as an “insurance death spiral.”

There are a number of policies Oregon could consider to help limit premium increases, maintain enrollment by healthier individuals and stabilize the individual insurance market so that it remains a valid route for Oregonians to obtain health coverage.

- **Adopt a state-level individual insurance mandate.** This would require all Oregonians to have health insurance or pay a tax penalty, compelling healthier customers into the market, lowering the average premium, and maintaining a steady level of risk for insurers. Massachusetts, New Jersey, Vermont, and Washington, D.C., have all adopted their own individual insurance mandates. Tax revenue from individuals who opt to pay the penalty instead of purchasing insurance can be used to help further stabilize the insurance market.
- **Explore a “public option.”** A public option would allow individual consumers to purchase a government-supported health plan akin to the Oregon Health Plan, which is the state’s Medicaid insurance program. Consumers would pay premiums on an ongoing basis to help cover health care and administrative costs, and the state may need to subsidize premiums for some consumers. A public option could increase choice for consumers in counties with few options. Risks

of a public option include driving private insurers out of some counties if the public option puts downward pressure on premiums, and splitting patients into healthy and unhealthy risk pools. No state has yet created a public option and Oregon would have to be a pioneer on this policy.

- **Protect consumers who are not eligible for tax credits from premium increases.** To cover federally mandated benefits that the federal government has stopped subsidizing, Oregon has allowed insurers to raise rates on benchmark insurance plans, enabling insurers to cover their costs and triggering higher federal tax credits for many consumers purchasing insurance on the exchange. However, consumers who earn too much to qualify for federal aid have had to pay more. Oregon could revise its rules so that premium increases are largely limited to consumers who receive federal tax credits. This approach is vulnerable to additional federal policy changes.
- **Consider enhancements to Oregon's reinsurance program to further limit how much insurers pay on behalf of consumers with especially high medical bills.** Currently, Oregon's program covers 50 percent of the medical bills for patients who purchased insurance in the individual market and who incur expenses between \$95,000 and \$1 million. Oregon could pursue changes to the program that might further reduce risk for insurers and enable them to charge lower premiums. For example, instead of or in addition to its current program, Oregon could

focus on patients with potentially high-cost medical conditions and try to improve management of their health. Experience in Maine and Alaska suggests this could reduce rate increases and allow better management of care for high-risk patients.

- **Shift control of Oregon's online health care market to the state instead of the federal government's online platform, HealthCare.gov.** This could reduce costs for insurers. Oregon insurers will pay an estimated \$25 to \$30 million to the federal government in 2019 for using the federal platform, up from \$16 million in 2018.<sup>15</sup> A state-run platform could be cheaper. Nevada, for example, expects to save \$5.5 million in the first year by switching to a state-run exchange.<sup>16</sup> In addition, full control of the online platform would enable the state to provide more effective outreach and assistance to individuals who need insurance, potentially increasing the number of people who successfully enroll.

Many of the steps that Oregon could take to stabilize the individual insurance market will be hard to maintain in the face of ever-increasing health care costs. To truly stabilize the individual health insurance market, maintain employer-based coverage, and keep government health care spending to a reasonable level, Oregon must broaden its efforts to address the underlying problem of high and rising health care costs. The state should seek opportunities to reduce health care spending by all payers in the state, while at the same time maintaining or improving the quality of care.

# Introduction

## OREGON'S ONLINE MARKETPLACE

for individual health insurance—a critical resource for people who do not have insurance through an employer-provided plan or government program—has survived. How long it will continue to function as a way for Oregonians to choose among affordable health plans is unclear.

Since its launch in 2014, Oregon's Affordable Care Act (ACA) exchange for individual health plans has weathered numerous challenges, including a website rollout plagued with technical problems, an exodus of insurers from the market, and now regulatory rollbacks by the federal government that threaten to undermine the ACA's foundations.<sup>17</sup> Despite these adversities, the exchange and other elements of the ACA have caused the percentage of the state's population that is uninsured to drop from 14 percent in 2013 to 6 percent in 2017.<sup>18</sup> By these metrics, the law seems to have delivered on its promise in Oregon to increase access to health coverage.

But the gains that the ACA has helped to deliver should not be taken for granted.

In the last couple of years, new threats have emerged to the stability of Oregon's health insurance exchange. Premiums have been rising, jumping an average of 9 percent in 2019.<sup>19</sup> While none of these

increases are as dramatic as the double-digit premium spikes that some states have experienced in recent years, they have exacerbated the financial stress of paying for health care, especially for Oregonians who do not qualify for subsidies.<sup>20</sup>

The increase in costs has coincided with a decline in options. In 2015, all counties in Oregon had three or more insurance companies offering plans on the exchange.<sup>21</sup> By 2019, 22 counties had only two insurers participating in the market, and residents of Douglas and Lincoln counties were served by only a single insurance company.<sup>22</sup> That means that a quarter of Oregonians purchasing insurance through the exchange had little or no choice of insurer. Three insurers who had participated in the individual insurance market in the first several years of the ACA ended or scaled back their offerings in 2016 after the federal government withdrew promised financial support for insurers.<sup>23</sup> Another insurer and its affiliate cited market uncertainty as the reason for their departures from 15 counties for 2018.<sup>24</sup>

While Oregon's exchange has survived, cracks have begun to emerge. After steady increases in enrollment since 2014, insurance enrollment in the exchange fell by 5 percent during the 2019 open enrollment period compared to the 2018 open enrollment period—the first

decline in enrollment in the history of the exchange.<sup>25</sup>

Oregon should take steps to shore up the exchange and ensure the existence of an effective marketplace for individual health care coverage with affordable premiums and choice for consumers. Any

tweaks Oregon makes to the exchanges, however, cannot fix the underlying issues that are pushing health care prices out of reach for millions of Americans. To address the full extent of this crisis and develop a truly stable exchange, Oregon will have to continue to innovate in how we pay for and receive healthcare.

# The High and Rising Cost of Health Care and Insurance in Oregon

## HEALTH CARE IS EXPENSIVE,

consuming a growing share of Oregon's economic output. As the cost of care has risen, health insurance has also become more expensive, leaving Oregonians in a bind. Without insurance, they may incur unbearable costs or need to skip necessary care to save money. Paying for insurance, however, can drain household budgets or be entirely out of financial reach for some consumers. Oregonians obtain insurance coverage through a variety of routes—such as employer-provided plans, government programs, and the private health insurance market for individuals—but rising costs threaten the viability of all those options.

## Health Care Is Expensive

In 2014, \$31.9 billion was spent on health care in Oregon, nearly 16 percent of the state's GDP, an average of \$8,000 per person.<sup>26</sup> Health care spending in Oregon increased by 29 percent from 2004 to 2014.<sup>27</sup> Spending has continued to increase since 2014, according to national data: in 2015 and 2016, nationwide expenditures on health care increased by 5.9 and 4.3 percent, respectively.<sup>28</sup>

Two of the biggest reasons for this growth in total health care spending are increasing prices and rising intensity of care.<sup>29</sup> Increasing prices mean that the average visit to a specialist, day in the hospital, or prescription drug refill costs more than previously was the

case. Higher intensity of care means more spending per patient visit to a doctor, due to the patient receiving more services, screenings and interventions at each visit. These two factors explain 50 percent of the increase in spending from 1996 to 2013. Population growth and an aging populace also drove up spending, responsible for 23 percent and 12 percent of the rise in health care spending, respectively.<sup>30</sup>

The burden of growing health care costs is perhaps better understood when compared to household income. In 2016, the total average cost (for both the employer and employee) of an employer-sponsored health care plan was 30.7% of median household income—double what it was in the late 1990s.<sup>31</sup>

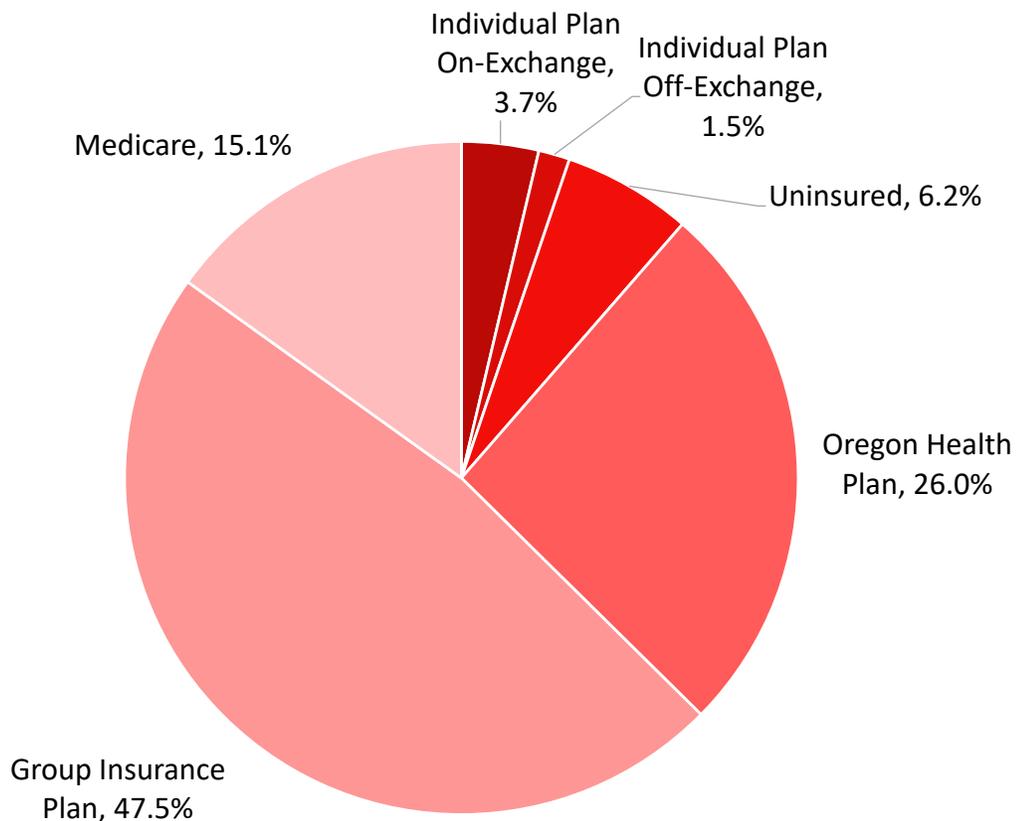
## Rising Health Care Costs Are Driving up Insurance Costs

Health insurance can help protect Oregonians from the potentially astronomical costs of receiving health care in the event of a major illness or injury. It also helps cover some routine health care costs, which for many families may be unaffordable without subsidized insurance. However, high prices in health care translate into expensive insurance. The high cost of health care and health insurance affects government budgets, the bottom lines of Oregon businesses, and the ability of households to make ends meet.

Ninety-four percent of Oregonians have health insurance, obtained through several avenues (see Figure 1):<sup>32</sup>

- Nearly half (48 percent) obtain insurance through private group plans operated by an employer, a college, a union or a business association.
- 26 percent of Oregonians receive their health insurance through the Oregon Health Plan, the state’s version of Medicaid.
- 15 percent obtain insurance through Medicare, the federal insurance program for older or disabled people.
- Approximately 5 percent of Oregonians are covered under individual plans, with 3.7 percent obtaining their coverage through the state’s health insurance exchange and the rest buying insurance outside of the exchange.<sup>33</sup> (See “How the Individual Online Marketplace Works.”) Slightly more than half of individuals who obtain insurance through the individual market receive a tax credit to help reduce their monthly premiums.<sup>34</sup>
- Roughly 6 percent of Oregonians are uninsured.<sup>35</sup> This is 8 percentage points lower than in 2013, before many major provisions of the federal ACA were implemented.

FIGURE 1. HOW OREGONIANS OBTAIN HEALTH INSURANCE<sup>36</sup>



## HOW THE INDIVIDUAL ONLINE MARKETPLACE WORKS

**IN 2014, THE AFFORDABLE CARE ACT** implemented online marketplaces, or “exchanges,” where individuals can shop for and purchase health insurance. Depending on the state, either the federal or state government runs the exchange. Most purchases occur during the annual enrollment period, which is November 1 to December 15 in most states.

The federal government provides advance tax credits to eligible customers on the exchange to offset the cost of their monthly premiums. Customers who earn up to 400 percent of the federal poverty level and buy insurance through the individual exchange qualify for these subsidies.<sup>37</sup> The federal government will pay the tax credit in advance each month directly to the individual’s insurer to reduce monthly premium payments.<sup>38</sup> (Other federal programs targeted at insurers have helped to reduce costs for individuals who buy insurance on or off the exchange.)

On the exchange, insurers choose on a county-by-county basis the types of coverage they want to sell. Plans are grouped by the generosity of coverage into bronze, silver, gold and platinum categories.<sup>39</sup> The amount of the tax credit which helps consumers with their insurance premiums is tied to the cost of plans in the silver category, which balance “moderate” premiums with moderate coverage.<sup>40</sup> Specifically, the silver plan with the second-lowest premium is the “benchmark” plan in its exchange.<sup>41</sup>

In addition to the state individual marketplaces, the ACA created marketplaces for small businesses. Under this program, businesses with 1 to 50 employees can offer insurance to their employees directly through an insurance company or with the help of a broker.<sup>42</sup> Selected small businesses may be eligible for a tax credit that can cover up to 50 percent of their premium payment for their employees’ health plans.<sup>43</sup>

The rising cost of health care means that the cost of providing or obtaining insurance has also been rising, putting a strain on individuals, businesses and government budgets.

Individuals and businesses face higher costs through employer-sponsored health insurance. In Oregon, the average annual price for a family insurance plan through an employer is \$17,953, with the typical

employee paying 27 percent (\$5,009) of the cost. These employee costs have increased by an average annual rate of 3.25 percent during the last four years.<sup>44</sup> Nationally, health insurance expenses for employers equaled 8.3 percent of employee compensation costs in 2017.<sup>45</sup> Employers compensate for higher health care costs by reducing benefits, limiting wage increases, or hiring fewer employees.<sup>46</sup>

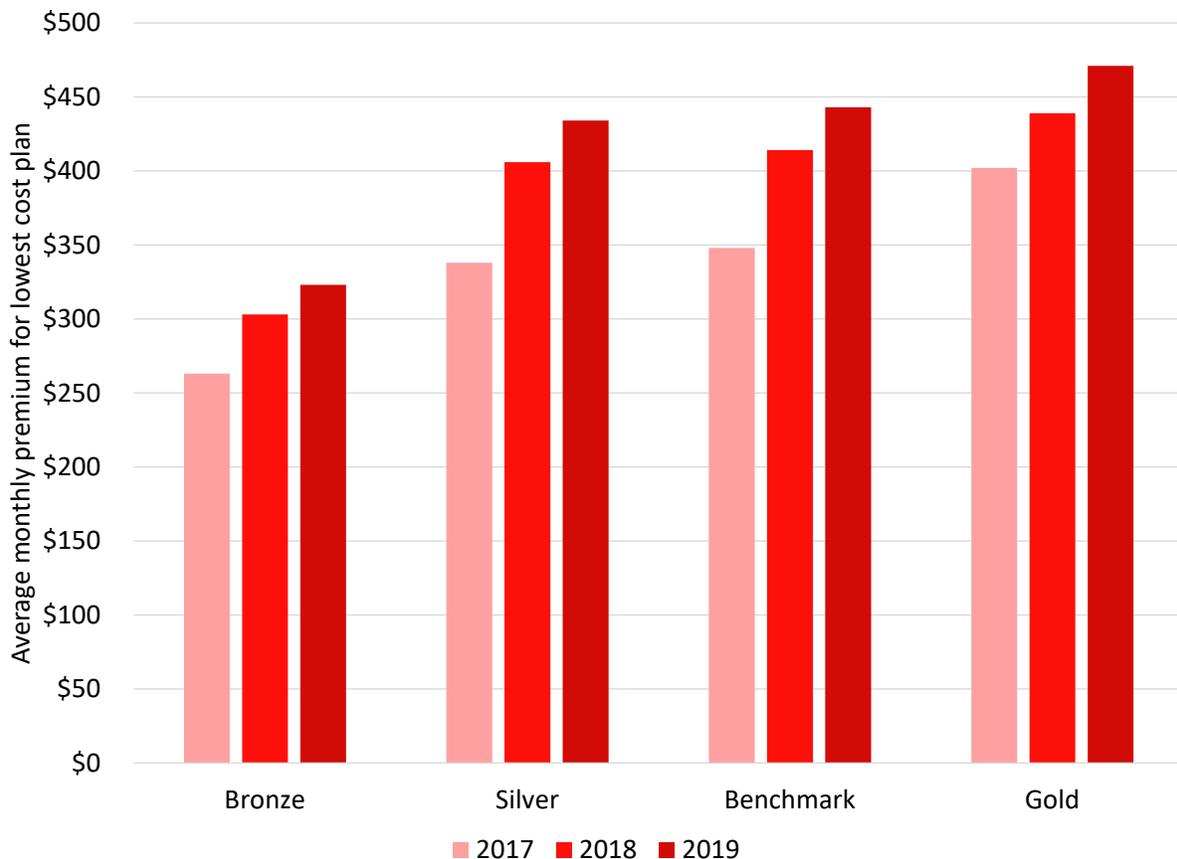
The rising cost of health care also affects government spending. For example, the state is currently struggling to fill a \$950 million funding shortfall for the Oregon Health Plan, the state’s Medicaid program.<sup>47</sup>

### Insurance Premiums Have Soared in the Individual Market

Oregonians who buy insurance for themselves and their families without participating in an employer- or government-run health plan face high and rising costs. Oregon consumers who do not qualify for tax credits to offset premium increases face a difficult decision of allocating more of their family’s budget to health insurance or going without insurance.

More than two-thirds of customers who buy individual insurance do so on the ACA exchanges.<sup>48</sup> The average premium for a benchmark plan in Oregon’s individual marketplace is \$443 in 2019, double what it was in 2014 (see Figure 2).<sup>49</sup> Because three-fourths of Oregonians who buy insurance on the exchange receive federal tax credits that reduce the cost of insurance premiums, individuals’ monthly premium costs are lower than this.<sup>50</sup> For example, a typical 40-year-old non-smoker living in Portland who selected a benchmark silver-level plan would pay \$209 in monthly premiums, after the tax credit.<sup>51</sup>

FIGURE 2. THE MONTHLY AVERAGE PREMIUM (BEFORE TAX CREDIT) FOR INDIVIDUAL EXCHANGE PLANS IN OREGON INCREASED FROM 2017 TO 2019<sup>52</sup>



As of the end of 2018, 54,000 Oregonians bought their individual insurance plans outside the exchange (compared to 119,000 who purchased plans through the exchange).<sup>53</sup> People who buy insurance off the exchange include people who do not qualify for tax credits—because they earn too much money, their immigration status disqualifies them, or

they otherwise aren't eligible—or who believe they do not qualify for tax credits.<sup>54</sup> The individual insurance market off the exchange is important for these groups. Premiums for plans off the exchange are linked to premiums on the exchange, and have similarly increased sharply in recent years.

# Changes to Federal Health Care Policies Are Destabilizing Oregon's Individual Insurance Market

**BEFORE ADOPTION OF** the federal Affordable Care Act (ACA), people who did not obtain insurance through an employer, a government plan or another group option struggled to buy insurance for themselves. Plans were expensive, offered limited coverage, and may not have been available at all to individuals with pre-existing conditions.

The ACA attempted to create a stable insurance market by mandating that all consumers have insurance, requiring insurers to sell insurance to everyone seeking to buy it, and limiting insurers' ability to charge higher prices to the sickest patients. These measures—and many less-visible supporting policies—enabled tens of thousands of previously uninsured or underinsured Oregonians to purchase comprehensive insurance in the individual market. The ACA's insurance market reforms also mean that people who might lose insurance from another source—because of a job change or earning too much money to qualify for the Oregon Health Plan—can purchase insurance on the exchange during times of transition.

Oregon's market for individual insurance has been destabilized by a range of forces in recent years. As discussed in the following sections in more detail, Congress and the Trump administration have lifted the penalty that enforces the mandate that individuals have insurance,

reduced outreach to help people enroll in insurance, approved less comprehensive insurance plans, ended payments to insurers that reduced their risk, and ended payments to insurers that covered their cost of serving lower-income customers.

These changes have reduced the number of consumers with insurance and have altered the ratio of healthy to sick consumers in the market. All of these changes have occurred in the context of continually rising health care costs.

The end result is insurers cover a sicker pool of patients and have experienced increased uncertainty, leading to higher health insurance premiums. A simplified explanation of how insurance works reveals how this process unfolds. Each insurer estimates how much it will need to spend in the coming year on health care for the group of customers it insures, and then collects payments from those customers, their employers, the government and/or other payers to cover its anticipated costs. This requires each insurer to estimate the amount of care its pool of customers will require, how much that care will cost, and how much revenue it will collect in premiums.

As uncertainty rises, insurers face a greater risk that their expenses may exceed their revenue. To limit their

potential financial losses, insurers may increase insurance premiums more than they otherwise would have, or withdraw from some insurance markets—leaving the people who previously had been covered without insurance or left to find other, possibly more expensive, insurance. However, higher insurance premiums may cause some healthier patients to skip buying insurance, changing the mix of insured customers and adding to uncertainty for insurers. These self-reinforcing problems destabilize the insurance market.

### **Fewer Healthy Consumers May Purchase ACA-Compliant Coverage**

Multiple federal policy decisions may be destabilizing to the individual insurance market by reducing the number of Oregonians who purchase insurance and also altering the mix of healthier versus sicker consumers who seek insurance.

Beginning in 2019, Congress has eliminated the penalty for individuals who fail to have health insurance that meets basic minimum standards.<sup>55</sup> This individual mandate was meant to widen the pool of those who have insurance, so that the cost of paying for health care would be spread across both sick and healthy consumers. The policy was implemented at the same time as a requirement that insurers sell coverage to all patients, including those who they previously might have excluded for being too sick. For insurers, a sicker pool of patients means higher average health care spending, while including healthier customers helps to lower that number.<sup>56</sup>

Multiple insurers in Oregon have expressed concern about the impact of the end of the penalty that enforced the in-

dividual mandate. In a 2019 rate filing, Kaiser Foundation Health Plan of the Northwest wrote “we anticipate that the removal of the Individual Mandate will cause a significant portion of lower risk members to leave the individual market across all carriers.”<sup>57</sup> Providence Health Plan wrote that it “expects a market contraction where healthier individuals are more likely to forego coverage.”<sup>58</sup> They and several other insurers cited the loss of the individual mandate as a factor for why they proposed higher rates in 2019.<sup>59</sup>

Another factor potentially influencing insurance enrollment is the administration’s sharp reduction in outreach for and shortening of the annual health insurance enrollment period.<sup>60</sup> For example, in the first year of Donald Trump’s presidency, the Department of Health and Human Services cut the enrollment period in half and reduced the advertising budget by 90 percent.<sup>61</sup>

In addition, the administration has eased rules on association health plans (AHPs), allowing self-employed individuals and a greater variety of businesses to band together to purchase insurance or even self-insure.<sup>62</sup> Looser rules regarding the coverage provided by AHPs potentially will allow them to reduce premiums below other health insurance options by offering less comprehensive coverage.<sup>63</sup>

The administration has also expanded access to short-term limited duration plans, which are temporary plans originally intended to remedy gaps in coverage. They do not have to comply with ACA rules, and can deny or charge higher rates for pre-existing conditions.<sup>64</sup> A new federal rule in August 2018 expanded the length that a customer is

allowed to be covered under a short-term limited duration plan from three months to one year. Moreover, consumers may now renew coverage for up to three years.<sup>65</sup> Oregon has imposed significant restrictions on short-term limited duration plans that may curtail their impact in the state, though such plans are still available.<sup>66</sup>

The expanded access to these cheaper and more limited AHPs and short-term limited duration health plans could trigger an exodus of healthier individuals from the individual marketplaces onto this alternative market.<sup>67</sup> One national study estimates that 3 to 10 percent of consumers on the individual exchanges could switch to AHPs in the coming years.<sup>68</sup> The study authors estimated that the majority of these consumers would be healthier than the average person buying insurance through an exchange, meaning their departure would shift the makeup of remaining consumers to be older and sicker. This would further push up premiums in the individual market.<sup>69</sup>

The impact of these forces on individual insurance enrollment through Oregon's exchange is unclear. Enrollment held steady from 2017 to 2018. However, for 2019, 8,000 fewer Oregonians purchased insurance through the individual exchange than in 2018.<sup>70</sup>

### **Insurers Receive Less Protection against Uncertainty and Risk**

In the first several years of the ACA's implementation, insurers faced large uncertainty about how healthy or sick new enrollees would be. To encourage insurers to set reasonable premiums despite this uncertainty and help create a stable market, the ACA included

several risk stabilization measures. Some of those measures were temporary, on the assumption that uncertainty about enrollee health would subside after several years. Two programs have ended and the administration has sent mixed signals about its willingness to continue a third, permanent risk stabilization measure. The result is that insurers have fewer risk protections at the same time they may face higher risks as healthier customers switch to less expensive and less comprehensive coverage under the new rules. This has the potential to increase insurance premiums and drive more consumers out of the market.

The first risk stabilization program was the "risk corridor" program, which redistributed revenue between all qualified health plans (both on and off the exchange) for the first three years of the exchanges (2014-2016). Plans whose costs were less than 77 percent of their premium revenue paid a share of their profits to the state agency overseeing the exchange. The agency passed that money to plans with costs that accounted for more than 83 percent of premium revenue.<sup>71</sup> Initially, the federal government planned to subsidize the program if payouts to insurers exceeded income from low-spending plans, but Congress stipulated that the policy had to be budget-neutral in 2015 and 2016.<sup>72</sup> The Obama administration promised to work with Congress when the program expired to secure any money owed to insurers under the original system, but the Trump administration has declined to pay more than \$12 billion of outstanding payments.<sup>73</sup> Several insurers sued, but an appeals court ruled against them.<sup>74</sup> While the court battle may continue, this experience may undermine insurers'

confidence that the federal government will fulfill its commitments.

The second expired program was a temporary re-insurance program that ended as planned in 2016. Every insurer (regardless of whether it sold plans in the individual market) contributed to a fund, supplemented by federal money, that reimbursed insurers whose enrollees in individual plans had unexpectedly high costs.<sup>75</sup> The fund distributed payments to insurers based on expensive, individual cases. This program may have had a large impact in reducing premiums. A study that modeled the impact of a re-insurance program estimated that it could reduce by 28 percent the extra amount that insurers charge based on the uncertainty of the patient's health costs.<sup>76</sup>

A third program, called "risk adjustment," is a more permanent part of the ACA but the Trump administration has wavered on implementing it. This policy also takes money from plans with low risk and gives it to those with higher risk.<sup>77</sup> Rather than being linked to profit margins, however, risk adjustment payments are based on the risk profile of each insurer's pool of patients. Insurers with sicker patients, and thus higher projected costs, receive a payment, while insurers with healthier patients and lower projected costs pay into the system. The program applies to all individual and small-group plans, whether on or off the exchange.

In July 2018, the administration froze \$10 billion in transfer payments after a lower court sided with small insurers who claimed the program disadvantaged them. Following an outcry from other insurers, the administration resumed the program two weeks later, triggering

additional legal challenges that are working their way through the federal court system.<sup>78</sup>

### **Insurers Face Mandates but Have Lost Funding**

Insurers are required to offer silver-level plans with lower out-of-pocket costs to qualifying, lower-income consumers. However, in late 2017, the administration eliminated cost-sharing reduction (CSR) payments to insurers that enabled the insurers to offer plans with lower co-pays.<sup>79</sup> The end of this payment—but not the end of the requirement for insurers—has led to higher premiums for some consumers as insurers have sought to cover their costs.

In Oregon, the premiums for benchmark silver level plans increased by 19 percent from 2017 to 2018.<sup>80</sup> Bronze plan premiums increased 15 percent and gold plans increased 9 percent over that same period. Premiums have risen fastest on silver-level plans because of a new pricing strategy that capitalizes on quirks of how the federal government calculates premium tax credits. The approach, known as "silver loading," entails purposeful premium increases on the silver plans to provide higher subsidies to consumers who qualify for tax credits. Oregon allowed silver loading in 2018, as did 42 other states.<sup>81</sup> Oregon approved silver loading again for 2019.<sup>82</sup>

For consumers who are eligible for subsidies, silver loading has little impact on the cost of plans purchased via the exchange because the subsidy rises as premiums rise.<sup>83</sup> Consumers who receive high premium tax credits may be able to obtain bronze-level coverage essentially for free.<sup>84</sup> In Oregon, 74 percent

of exchange participants qualified for premium tax credits in 2018, while 26 percent—those who earned more than the tax credit cutoff of \$100,400 for a family of four—did not qualify.<sup>85</sup>

Consumers who do not qualify for tax credits or who buy their insurance off the

exchange have had to pay more.<sup>86</sup> That's because premium rates for plans on and off the exchange are linked, and only low- and moderate-income customers who purchased insurance through the exchange received an offsetting increase in their premium subsidy.

# Options for Oregon to Help Support a Functioning Individual Market for Health Insurance

## THE LOSS OF STABILIZATION

programs and payments to insurers, combined with the elimination of the individual mandate and the potential rise in non-ACA compliant plans, have inserted a new level of uncertainty into the individual insurance market. Some of these changes are already leading to higher premiums and reduced enrollment while the effects of others have yet to be fully realized.

In light of this, states are examining a variety of policy responses to add stability to the market. Oregon, for instance, could replace some of the federal programs and regulations with state-level versions, such as an individual mandate. Another option for the state would be to revise some of its current policy interventions, such as reinsurance and “silver loading,” to further lower premiums. It could also experiment with new solutions. Adoption of a “public option,” which would allow some residents with otherwise limited access to insurance to buy into the Oregon Health Plan or another government-organized health plan, would be the first of its kind in the country.

Action at the state level could help to stabilize the individual insurance market and lower premiums in the short term. Separately, Oregon needs to pursue other policies to address the underlying problem of high health care costs or the insurance market will never fully stabilize.

## Adopt a State-Level Individual Insurance Mandate

Oregon could adopt a state-level individual mandate and penalty to fill the gap left by the repeal of the federal tax penalty for the individual mandate starting in 2019. Without such a policy, the pool of patients within the exchange may become sicker. The idea behind the mandate was that if everyone were required to purchase insurance, it would compel healthier customers into the market, thus lowering spending per patient for insurers and lowering the average premium.<sup>87</sup> Without the individual mandate, healthier consumers may leave the exchange in favor of lower-cost association health plans, short-term limited duration plans, or no coverage at all.<sup>88</sup>

To help keep healthier consumers in the insurance market, three states plus Washington, D.C., have adopted state-level individual mandates.<sup>89</sup> In 2006, Massachusetts created an individual insurance mandate, a full eight years before the federal version took effect.<sup>90</sup> The three other jurisdictions that have adopted similar legislation—New Jersey, Vermont and Washington, D.C.—all did so after the repeal of the federal individual mandate.<sup>91</sup> Several other states, including Washington and Maryland, have considered similar statutes.<sup>92</sup>

The adopted state-level mandates are very similar to the now-repealed federal

mandate, in that all require an individual and their dependents to have some basic amount of insurance or pay a tax penalty. In New Jersey and Washington, D.C., the penalty is the greater of \$695 per adult and \$347.50 per child, or 2.5 percent of the taxpayer's income. This penalty is capped at the premium rate of an average bronze plan in the marketplace.<sup>93</sup>

Each state with a mandate has established its own standards for how comprehensive an individual's insurance plan must be to satisfy the mandate requirement.<sup>94</sup> The federal standard had required consumers to have a plan that was equivalent at least to a bronze-level plan.<sup>95</sup>

Additionally, every state that has instituted an individual mandate has also created exceptions that exempt individuals from purchasing insurance due to religious beliefs, incarceration, a lack of affordable options or other factors.<sup>96</sup> States considering an individual mandate must balance the need for exceptions without making it too easy for capable taxpayers to avoid paying the penalty, which was a weakness of the federal requirement.<sup>97</sup> Massachusetts, for instance, has a sliding scale based on income to determine affordability, which is different than the static 8 percent of household income standard the federal government adopted.<sup>98</sup>

While it's too early to know how the individual mandates in New Jersey, Vermont and the District of Columbia will affect their insurance markets, the long-standing policy in Massachusetts likely helped to increase the number of people participating in the health care market and lower the state's uninsured population to 2.5 percent—the smallest

percentage in the country.<sup>99</sup> However, Massachusetts' mandate is just one part of a larger state government operation that has combined subsidized insurance options with targeted outreach, resulting in the second-lowest cost benchmark plans in the country in 2017 and 2018 and a growing number of health insurance purchasers who do not receive subsidies.<sup>100</sup>

A mandate can generate tax revenue from individuals who opt to pay the penalty instead of purchasing insurance. States have adopted or considered different approaches to using these funds to stabilize insurance markets and help consumers buy insurance. There is nothing to stop a state from using this tax revenue for general fund purposes, though to date no state has done this. New Jersey, for instance, will assign the money (estimated to be \$90 to \$100 million annually) to a reinsurance program, which will distribute funds to insurers with high cost patients.<sup>101</sup> Massachusetts uses part of its mandate revenue to supplement federal funds that make premiums more affordable for low and middle-income consumers in the exchange.<sup>102</sup>

In Oregon, adopting an individual mandate could both lower insurance premiums in the individual market and increase the number of people with insurance. Multiple insurers in Oregon have cited the loss of the individual mandate tax penalty as one reason they proposed higher premiums for 2019, based on an assumption that healthier consumers would leave the market.<sup>103</sup>

If Oregon were to adopt an individual mandate, it could generate \$70 million

to \$80 million in new tax revenue.<sup>104</sup> This amount could be used to partially fund the state's existing reinsurance program, supplement premium tax credit subsidies or be used to fund other public health programs.

### **Explore a Public Option**

Oregon could explore creating a "public option," allowing consumers to purchase government-supported health insurance just as they would a private health plan. A public option could stabilize the market if it were offered in counties where consumers otherwise would have no insurance choices on the exchange or if it were targeted at consumers who do not qualify for premium tax credits through the exchange or who do not otherwise have insurance.

There are several ways to structure a public option. The most widely discussed in Oregon is a Medicaid buy-in program offered by the coordinated care organizations (CCOs) that participate in the Oregon Health Plan (Oregon's Medicaid program).<sup>105</sup>

#### *CCO Medicaid Buy-In*

One way to create a public option would be to encourage or require Oregon's Coordinated Care Organizations (CCOs) to sell insurance plans in the individual market.<sup>106</sup> This would essentially create a Medicaid buy-in program that could stabilize the insurance market if targeted at Oregonians who are currently uninsured or who, for a variety of reasons, do not qualify for federal tax credits or the Oregon Health Plan.

CCOs are networks of physical, mental and dental health providers that administer care for the state's Medicaid

program, the Oregon Health Plan. In 2012, the state of Oregon established 16 CCOs (now 15) to control spending and increase the quality of care in the Oregon Health Plan.<sup>107</sup> These organizations are given a fixed budget by the state and then held responsible for both the costs of health care as well as the quality of patient care. By coordinating a patient's care amongst their providers, CCOs have lowered emergency care utilization and preventable hospitalizations. While there is still some debate on how effective CCOs have been, by many metrics they have held costs down and improved patient outcomes.<sup>108</sup>

A CCO-based public option would entail these organizations expanding their mission to operate similarly to insurers that offer highly integrated and coordinated health care services.

Offering a CCO-based public plan on the exchange most likely would require a waiver from the federal government, which needs to approve changes to health insurance offerings under the ACA that could reduce enrollment, limit coverage or affect the federal deficit.<sup>109</sup> The current administration is unlikely to grant such a waiver.<sup>110</sup> Oregon has more leeway with plans offered off the exchange.

Off the exchange, CCOs could offer individuals coverage at a premium and co-pay rate that would cover administrative and health care costs.<sup>111</sup> CCOs could offer either a full-benefit plan identical to what is offered through the Oregon Health Plan, or a reduced coverage plan that would eliminate benefits for vision and/or adult dental care. Because this version of Medicaid buy-in would be offered off-exchange,

consumers would not be able to receive premium tax credits.<sup>112</sup> Thus, the state may need to subsidize premiums for some consumers.

### *Cost and Market Implications*

Several states have considered creating a public option. The Nevada legislature passed a bill in 2017 that would have created a Medicaid buy-in option, but it was vetoed by the governor.<sup>113</sup> Several other states have introduced legislation that would create a similar program.<sup>114</sup> Because a public option has not been adopted or implemented anywhere, there are no real-world examples that can demonstrate its benefits and drawbacks.

New Mexico recently completed a study of a limited Medicaid buy-in option that would be offered to people who do not qualify for tax credits on the exchange, or for Medicare or Medicaid. The proposed plan would not require approval or assistance from the federal government. The study estimated premiums would be up to 15 to 28 percent lower than monthly premiums for private plans, depending on the mix of consumers who select a Medicaid buy-in option and the coverage they otherwise might have purchased.<sup>115</sup> New Mexico would subsidize insurance on an ongoing basis for some of these consumers. Depending on which consumers enroll and the size of the subsidies, New Mexico could spend up to \$71 million in the first year to subsidize coverage for approximately 23,000 people. An additional 6,000 people would choose the Medicaid buy-in option and not receive any subsidy.

If offered in competition with private insurers, a public plan could put downward pressure on premiums

and cause some private competitors to withdraw.<sup>116</sup> To avoid this destabilizing impact, Oregon might want to limit the availability of the public option to customers who are unlikely to otherwise have insurance.

In addition to the risk of causing private insurers to withdraw from some markets, the public option has several other potential drawbacks. A widely available public option could cause significant shifts in the health of the insured population purchasing insurance from private carriers.<sup>117</sup> For example, sicker patients might choose to stay with private insurers while healthier patients who use relatively little care could switch to the public option. This would raise costs and destabilize the private insurance market. It is also possible that sicker patients would gravitate to the public option.

A final hazard of offering a public option through CCOs is that it could make it harder for them to meet their current goals of serving patients in the Oregon Health Plan while improving the value of care they provide.<sup>118</sup>

### **Revise “Silver Loading” to Protect Consumers Not Eligible for Tax Credits**

In response to the abrupt end of the cost-sharing reduction payments in 2017 that had reimbursed insurers for meeting the requirement that they offer low-deductible plans to qualified customers, many states began to encourage the practice of “silver loading.” This strategy entails insurance companies raising their rates in the silver category of plans, which are the plans that offer lower deductibles to selected consumers and also provide the benchmark for determining tax credits. Higher premiums for silver

plans mean eligible consumers who buy insurance through the exchange can receive higher tax credits, regardless of which level of plan they purchase. The purpose of silver loading is to keep premiums as affordable as possible and enable participation in the individual health care market by all consumers who need to purchase care, thus maintaining a stable individual market.

With the higher subsidies, some consumers paid less for insurance in 2018 than 2017, despite a steep increase in monthly premiums for insurance plans.<sup>119</sup> However, customers who do not qualify for tax credits must pay higher premiums, which increases the risk that healthy consumers may opt not to buy insurance at all.

Oregon currently allows its insurers to silver load. However, the state's current approach raises premiums for the 26 percent of Oregon exchange participants who do not receive premium tax credits and for those who choose to buy insurance outside the exchange.<sup>120</sup>

In contrast, many states have insurers confine their silver loading premium increases to on-exchange silver plans only, while offering a modestly priced silver plan off-exchange. This policy, colloquially known as the "silver switcheroo," increases the premium tax credits for plans purchased on the exchange while giving customers who do not qualify for the credits the ability to shop for more affordable plans off the exchange.<sup>121</sup>

Oregon could adopt the silver switcheroo, which may keep more consumers in the individual insurance market. States that

have adopted a switcheroo policy have allowed insurers to make subtle changes to the cost-sharing structures of the plans. This enables the insurers to offer virtually identical plans off the exchange without technically breaking federal law.<sup>122</sup>

While the federal Department of Health and Human Services (HHS) initially threatened to shut down the practice, in August 2018 the agency reversed its stance and blessed "silver loading."<sup>123</sup> HHS also recommended that states follow the "switcheroo" model and offer similar but cheaper plans off the exchange. The policy is currently accepted by the administration, but it indicated in early 2019 that it is considering banning the practice in 2021.<sup>124</sup>

Silver loading and the silver switcheroo are the result of states trying to cope with federal policy changes that make it harder to maintain stable individual markets that allow as many people as possible access to health insurance. These policies are not logical by themselves nor are they a sensible way to design a health insurance market, but can be a rational response to the incentives provided under the current structure of the ACA.

### **Consider Enhancements to the Oregon Reinsurance Program**

With creation of the Oregon Reinsurance Program in 2017, Oregon was one of the first three states to implement a reinsurance program. In these programs, a government-controlled fund pays a portion of the expenses for high-cost enrollees in a health plans purchased in the individual market.<sup>125</sup> This reduces risk and costs for insurers, potentially resulting in more affordable plans, retaining customers in the individual

insurance market, and providing greater stability. The policy decreased premiums in Oregon by 6 percent in 2018 and by 6.3 percent in 2019.<sup>126</sup> By modifying its reinsurance program, Oregon potentially could further lower both premiums and overall health care costs.

Under Oregon's current policy, insurers pay only 50 percent of their customers' medical bills if the expenses are between \$95,000 and \$1 million, and the state covers the other 50 percent of the costs.<sup>127</sup> Oregon has several sources of revenue to pay for the program. The state taxes insurers based on the premiums they collect from customers.<sup>128</sup> Oregon also receives funds from the federal government. Because the reinsurance program lowers premiums and reduces how much the federal government must spend on premium tax credits, the ACA allows Oregon to receive federal funding equal to the federal savings.<sup>129</sup> Additionally, the program received one-time funding from the remaining balance of a former state insurance program for those with pre-existing conditions (the Oregon Medical Insurance Pool Account) and excess balance from the Oregon Health Insurance Exchange.<sup>130</sup>

Although Oregon's program has already succeeded in achieving premium reductions and therefore improving market stability, revisions might increase the impact of the policy by better managing the care of the sickest customers, further lowering premiums and retaining more healthy customers.

One option Oregon could consider would be to increase funding for the program.<sup>131</sup> More funding could enable the state to begin reinsurance when patient expenses

are lower than \$95,000 or to increase the percentage of reimbursement. This would lift even more costs away from insurers and reduce premiums for consumers, helping to keep healthy consumers in the individual market.<sup>132</sup>

Another option Oregon could evaluate would be to revise the reinsurance program to focus on patients with high-cost conditions, in addition to or instead of patients who have high medical expenses in a given year.<sup>133</sup> With "condition-based reinsurance" or "invisible high-risk pools," a government-controlled fund pays for much of the care of patients with certain medical conditions.<sup>134</sup> The patient pays premiums to the insurer and uses the provider network for their insurance plan, but most of their premium payments are transferred to the government. In return, the government pays the insurer for most of that patient's health care costs above a certain threshold.<sup>135</sup>

Maine operated such a program in 2012 and 2013, before implementation of the ACA.<sup>136</sup> To address the intertwined problems of rising premiums and the flight of young, healthy individuals from the insurance market, Maine identified eight conditions that were considered "high-cost" and then automatically enrolled patients with those medical conditions into its reinsurance program. Maine also allowed insurers to voluntarily place patients into the pool. Insurers surrendered the majority of those consumers' premiums to the reinsurance program yet had to pay for up to \$10,000 worth of care. This payment structure deterred insurers from transferring too many patients to the reinsurance program. As a result, insurers chose to add only 10 percent of their patients not identified as high-cost to the government program.<sup>137</sup> The ceded premiums paid for around 42 percent of

the government pool's medical claims. To cover the rest of the costs, Maine collected a \$4 monthly fee on all health plans.<sup>138</sup> Coupled with other policies adopted by Maine, individual premiums fell dramatically in 2013 as insurers were exposed to less risk.<sup>139</sup> The program was canceled in 2014 when temporary federal reinsurance started, but Maine is resuming its program for 2019.<sup>140</sup> For 2019, the reinsurance program has reduced rate increases to an average of 1 percent, versus 9 percent if Maine didn't have a reinsurance program.<sup>141</sup>

Alaska set up a condition-based reinsurance program in 2016 after being faced with a predicted 42 percent increase in premiums.<sup>142</sup> With the reinsurance program, premiums in the individual market increased just 7 percent.

Alaska's condition-based reinsurance system also includes a provision to help better manage care for patients in the high-risk pool.<sup>143</sup> This has the potential to reduce overall medical costs.<sup>144</sup> Oregon already has some experience addressing the needs of patients with particularly high health care costs, through CCOs that participate in the Oregon Health Plan.<sup>145</sup> Whether revisions to Oregon's existing reinsurance plan would provide additional market stabilization or help reduce overall spending would require further study.

### **Have Oregon, Not the Federal Government, Operate the State's Online Health Care Market**

Currently, Oregon's health exchange operates on the federal online platform, HealthCare.gov. Customers who want to purchase insurance in the individual market and learn if they are eligible for a

subsidy go to the federal website. Oregon could save money, provide more effective outreach and assistance to individuals who need insurance, and gain flexibility to accommodate future reforms by switching its exchange to a fully state-run platform.

In the first year of the ACA, Oregon built and used its own technology platform.<sup>146</sup> However, the system was so plagued with technical issues that the state had to rely on paper applications for the first four months of enrollment.<sup>147</sup> The next year, Oregon contracted with the federal government to use its eligibility and enrollment software, while the state continued to perform consumer outreach, certify qualified health plans, and provide other functions.<sup>148</sup>

Oregon is one of five states that rely on this hybrid model.<sup>149</sup> Initially, insurers in Oregon paid nothing to use the federal site, but starting in 2017, the federal government charged insurers a fee equivalent to 1.5 percent of the value of the annual premiums sold on the exchange. The Centers for Medicare and Medicaid Services then raised this fee to 2 percent in 2018 and 3 percent in 2019.

Rising fees coupled with rising insurance premiums mean that Oregon's insurers send more money to the federal government every year. In 2018, health plans paid \$16 million in fees and in 2019 this number is expected to increase to between \$25 and \$30 million.<sup>150</sup> These fees are ultimately passed onto consumers, leading to higher premiums for health insurance purchased on the exchange.

Oregon might be able to reduce exchange operation costs if it left the federal

platform and created its own system. In 2016, the state solicited bids from technology vendors who have experience running exchanges in other states.<sup>151</sup> However, government officials decided to keep using HealthCare.gov because switching to a state-run platform would have been marginally more expensive. They made plans to revisit the option in a couple years when options may have improved.<sup>152</sup>

Other states are also looking to end their reliance on the federal platform. Nevada will leave the federal platform for a state-run platform in 2020. The switch is expected to save \$5.5 million in the first year alone—almost half of what Nevada would have paid to the federal government.<sup>153</sup>

In addition to financial savings, a move to a state system can also provide the state with more freedom and information. For example, as part of the Trump administration's changes to the ACA, the enrollment period was cut in half.<sup>154</sup> States

that rely on HealthCare.gov have had to adopt this truncated timeline, but others with their own exchanges retained the ability to offer a longer enrollment period, potentially boosting the number of people who purchase insurance on the individual exchanges.<sup>155</sup>

Improved access to real-time data by state officials could also help enrollment. Currently, state officials must wait until after the enrollment period is over to receive registration lists and data.<sup>156</sup> If they had immediate access to this information, officials could better target their outreach and support for customers. In fact, one of Oregon's complaints about the exchange is that the customer support specialists at HealthCare.gov are not very knowledgeable about Oregon options.<sup>157</sup> If Oregon were to create its own technology platform, it would have access to real-time data and control the entire customer support operation, potentially leading to more informed and responsive consumer help.<sup>158</sup>

# | Conclusion

**OREGON COULD PURSUE** a number of strategies to stabilize its market for individual health insurance. Some approaches would require the state to reevaluate programs it already has implemented, such as silver loading and the current reinsurance program, to see if revisions would produce greater stability to the market by encouraging healthier patients to remain and reducing risks for insurers. Other options, such as a state-level mandate that consumers have health insurance, have been successfully demonstrated by other states. Finally, Oregon could pioneer policies such as a public option by allowing targeted consumers to buy in to a version of the Oregon Health Plan.

Yet many of the steps that Oregon could take to stabilize the individual insurance market will be hard to maintain in the

face of ever-increasing health care costs. Though the state has had some success slowing health care spending in the Oregon Health Plan, with spending in that program rising more slowly than national health care spending, many challenges remain. The Oregon Health Plan accounts for just a portion of total health care spending in the state, which has continued to rise rapidly.

To truly stabilize the individual health insurance market, maintain employer-based coverage, and keep government health care spending to a reasonable level, Oregon must broaden its efforts to address the underlying problem of high and rising health care costs. The state should seek opportunities to reduce health care spending by all payers in the state, while at the same time maintaining or improving the quality of care.

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