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# STATE OF OREGON
## LEGISLATIVE COUNSEL COMMITTEE

May 27, 2011

Representative Ben Cannon
900 Court Street NE H484
Salem OR 97301

Re: A-engrossed Senate Bill 99, Oregon Health Insurance Exchange

Dear Representative Cannon:

You have requested an opinion on the following questions:

1. *Would any provision of federal law, state law, or SB 99A, if adopted, prohibit the Exchange Corporation from:*

    - *Acting as an active purchaser that uses market tools such as managed competition to lower costs?*
    - *Negotiating on costs and quality?*
    - *Excluding plans with premium increases that are unjustified?*

2. *What is the practical effect of the last sentence of Section 11 (4)? Would it prohibit any of the activities mentioned in question 1 above?*

The short answer is that nothing in federal or state law or in A-Engrossed Senate Bill 99 would prohibit any of the activities you have described.

Federal law

Sections 1311 and 1321 of the Patient Protection and Affordable Care Act (P.L. 111-148) require the establishment of American Health Benefit Exchanges by January 1, 2014. States may implement their own exchanges or may form regional or interstate exchanges with other states. If a state fails to implement its own exchange, the federal government is required to operate the exchange within the state.[1]

*Active purchaser model and negotiations on costs and quality*

The federal Act sets out the general requirements for an exchange, and those requirements are to be more fully developed by regulations promulgated by the United States Department of Health and Human Services (HHS). The federal Act does not explicitly address whether the exchange may act "as an active purchaser that uses market tools such as managed competition to lower costs" or may negotiate "on costs and quality." However, the Act does describe an exchange that is intended to lower premium costs and improve services offered by the "qualified health plans" that would be allowed to participate in an exchange. For example, 42 U.S.C. 18031(c)(4) requires the Secretary of HHS to "develop a rating system that would rate

[1] 42 U.S.C. 18031; 42 U.S.C. 18041.

qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price." In addition, each exchange must make available through an Internet portal "a calculator to determine the actual cost of coverage after the application of any premium tax credit . . . and any cost-sharing reduction."[2] The Act does prohibit the exclusion of any health plan from participating in an exchange "through the imposition of premium price controls," but we do not understand price controls to be implicated in an "active purchaser" model or in the negotiation of costs and quality. Indeed, the federal Act appears to envision the exchange as a vehicle for enhancing the competitive marketplace.

*Exclusion of plans with premium increases that are unjustified*

The federal Act does speak directly, however, to the consideration of unjustified premium increases when approving a health plan for participation in an exchange. 42 U.S.C. 18031(e)(2) provides:

> The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act[3] . . . into consideration when determining whether to make such a health plan available through the Exchange.

*Federal regulations*

HHS has not issued proposed regulations, but did issue some initial guidance to states.[4] The guidance included the following comments:

- "Exchanges should have the flexibility to respond to local market conditions and take actions to facilitate competition among plans on price and quality."
- Exchanges "will have the flexibility to deal with insurers, agents, and other business partners in a manner that serves the Exchange's interest in maximizing value for consumers."
- "States have a range of options for how the Exchange operates from an 'active purchase' model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers."

If the federal regulations promulgated by HHS follow the path of the initial guidance, it appears that the regulations will not only allow, but will encourage exchanges to act as an "active purchaser" and to negotiate on quality and costs.

<u>The effect of section 11 (4) of A-Engrossed Senate Bill 99</u>

The last sentence of section 11 (4) of A-Engrossed Senate Bill 99 provides that "[t]he corporation may limit the number of qualified health plans that may be offered through the

[2] 42 U.S.C. 18031(d)(4)(G).
[3] This section relates to patterns or practices of excessive or unjustified premium increases.
[4] <http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html>.

exchange as long as the same limit applies to all insurers." The practical effect of the sentence is to permit the Oregon Health Insurance Exchange Corporation to impose a numerical limit on the number of qualified health plans that may be offered by insurers through the exchange as long as the same limit applies to all insurers. The intent was to avoid flooding the exchange with so many plans that consumers would be overwhelmed with the choices. So, for example, if Insurance Company A is permitted to offer five plans through the exchange, then Insurance Companies B through X may also offer up to five plans through the exchange.

There is no guarantee, however, that an insurer will have any health plans certified as qualified health plans. To be certified, a health plan must meet the requirements, standards and criteria established by the corporation by rule. The corporation would be authorized, but not required by the language in section 11 (4), to adopt requirements, standards and criteria that would allow the corporation to act as an active purchaser and to negotiate costs and quality in determining which health plans may be certified as qualified health plans.

The federal Act requires the corporation to "take into account" unjustified premium increases in determining which health plans may participate in the exchange. Therefore, the corporation could also prescribe certification criteria that exclude plans with unjustified premium increases.[5]

We understand from listening to the testimony on Senate Bill 99 that there are competing interpretations of the last sentence of section 11 (4). You did not request an opinion on those interpretations. We would like to offer our view on those interpretations in case that might be helpful to your consideration of the bill.

Some stakeholders have suggested that the sentence eliminates competition in the exchange marketplace. This might be partly true if the corporation imposed a cap of one on the number of health plans that each insurer could offer through the exchange. Even so, there would be competition among insurers to offer the most attractive plan possible, in terms of quality and price.

The bill requires the corporation to "screen, certify and recertify health plans as qualified health plans according to federal and state standards and ensure that qualified health plans provide choices of coverage."[6] The corporation must decertify health plans that fail to meet the standards.[7] The standards adopted by the corporation must ensure that qualified health plans offer, at a minimum, "essential health benefits and have acceptable consumer and provider satisfaction ratings."[8] This would prohibit the corporation from certifying health plans that failed to provide sufficient value to consumers.

The corporation is required to grade each plan and provide to consumers the grade of each plan, "quality and enrollee satisfaction ratings," and "[t]he comparative costs, benefits, provider networks of health plans and other useful information."[9] Even with a cap of one, insurers would thus be encouraged to compete to showcase plans that have the highest grade and are most attractive to consumers in terms of enrollee satisfaction, cost, benefits, provider networks and similar factors.

[5] Section 3 (1)(d) of SB 99-A requires the corporation to "screen, certify and recertify health plans as qualified health plans according to federal . . . standards."
[6] A-engrossed Senate Bill 99, section 3 (1)(d).
[7] *Id.* at section 3 (1)(e).
[8] *Id.* at section 11 (4).
[9] *Id.* at section 3 (1)(b)(A) to (C).

Other stakeholders have suggested that if the sentence was deleted, it would allow the corporation to engage in "selective contracting" or contracting with only a small number of insurers. However, subsection (4) of section 11 has nothing to do with whom the corporation chooses to contract. The subsection addresses the *health plans* that may be offered by each insurer through the exchange. A health plan is not an insurer, it is the product offered by an insurer.[10] On the other hand, subsection (3) of the section does prohibit the corporation from engaging in selective contracting. It provides that "[a]ny qualified health plan must be certified." Therefore, the corporation does not have the flexibility to contract with selected insurers. If an insurer has a health plan that meets the criteria for certification, the corporation must certify the plan so long as the insurer is not already offering a number of health plans equal to any limit imposed by the corporation under subsection (4).

Therefore, we disagree with both stakeholders groups' interpretation of the effect of the last sentence of section 11 (4).

State law

You also asked if any provisions of state law would prohibit any of the activities that you described. Because a health insurance exchange is a totally new concept, all of the applicable requirements are contained within the bill. We are not aware of any other provisions of state law that would interfere with the corporation engaging in any of the activities that you described.

The opinions written by the Legislative Counsel and the staff of the Legislative Counsel's office are prepared solely for the purpose of assisting members of the Legislative Assembly in the development and consideration of legislative matters. In performing their duties, the Legislative Counsel and the members of the staff of the Legislative Counsel's office have no authority to provide legal advice to any other person, group or entity. For this reason, this opinion should not be considered or used as legal advice by any person other than legislators in the conduct of legislative business. Public bodies and their officers and employees should seek and rely upon the advice and opinion of the Attorney General, district attorney, county counsel, city attorney or other retained counsel. Constituents and other private persons and entities should seek and rely upon the advice and opinion of private counsel.

Very truly yours,

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[10] The term is defined in section 1 of the bill.